United States v. State of Nebraska

Monitoring Team Report

Dates of Onsite Reviews: April 7 through 11, 2014, and
May 28 through 30, 2014

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Introduction

I. **Background** - In 2007, the United States Department of Justice (United States) notified the State of Nebraska (State) of its intent to investigate the Beatrice State Developmental Center (BSDC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The United States conducted onsite reviews of BSDC (the Facility) between October 15 and 19, 2007. On March 7, 2008, the United States notified the State that it had reasonable cause to believe that individuals at BSDC were being subjected to conditions that deprived them of their legal rights, and of their rights, privileges and immunities guaranteed them by the Constitution of the United States. The State and the United States entered into a Settlement Agreement, which was entered as an Order and Judgment of the Court, effective July 2, 2008. The Settlement Agreement covers any individual who was a resident of BSDC on October 19, 2007, the day on which the United States finalized its onsite tour of BSDC, including those individuals who have moved to community settings since October 19, 2007.

After the resignation of the original Independent Expert in late 2009, pursuant to the Settlement Agreement, on December 22, 2009, the parties submitted to the Court their selection of Maria Laurence as the replacement for the Independent Expert. The Independent Expert is responsible for conducting reviews of BSDC, as well as community settings to which individuals residing at BSDC as of October 19, 2007, are now residing, to determine the status of the State's progress in meeting the requirements of the Settlement Agreement. Monitoring visits are to occur quarterly. After the completion of such visits, the Independent Expert is responsible for detailing her team's findings, as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, the Independent Expert has engaged an expert team (Monitoring Team). This team includes consultants, who, along with the Independent Expert, have expertise in nursing and medical services, psychiatry, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, and placement of individuals in the most integrated setting appropriate to their needs.

The Independent Expert's role is to assess and report on the State's status with regard to the provisions of the Settlement Agreement. Part of the Independent Expert's role is to make recommendations that the Monitoring Team believes might help the State achieve compliance. It is important to understand that the Independent Expert's recommendations are suggestions, not requirements. The State is free to respond in any way it chooses to the recommendations, and/or to use other methods to achieve compliance with the Settlement Agreement.

Pursuant to Paragraph II.D.14 of the Settlement Agreement, the Independent Expert submitted a draft of this report to the parties on November 11, 2014. The parties had 15 business days until December 3, 2014, to provide comments on

the draft report to the Independent Expert. The State submitted comments on November 17, 2014. The United States did not submit comments.

II. **Methodology -** In order to assess the State's status with regard to the provisions of the Settlement Agreement, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – The Monitoring Team visited Beatrice State Developmental Center, as well as community homes and day/vocational programs for individuals that moved from BSDC, and also met with State Office staff responsible for the oversight of community services. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitoring Team arrived. This allowed the Monitoring Team to gain some basic knowledge about the State's current practices prior to arriving on site and to expand that knowledge during the week of the onsite review. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services, as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Individual Personal Plans (IPPs), Behavior Support Plans (BSPs), documentation of plan implementation, progress notes, transition plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the State. In other instances, particularly when the State recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, IPP team meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team spoke with a number of individuals served by the State.

III. **Organization of Report –** The report is organized to provide an overall summary of the State's status with regard to provisions within the Settlement Agreement, as well as specific information on each of the paragraphs in Sections III.A.1 through III.D.140 of the Settlement Agreement.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the State's progress in implementing the provisions of the Settlement Agreement. This section highlights, as appropriate, areas in which the State has made significant progress, as well as areas requiring particular attention and/or resources.

For each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Status:** The steps the Monitoring Team took to assess compliance are described, including documents reviewed, meetings attended, and persons interviewed. This section provides detail with regard to the methodology used in conducting the reviews, which is described above in general;

(b) **Assessment of Status:** Included in this section are detailed descriptions of the State's status with regard to particular components of the Settlement Agreement, including, for example, evidence of the current status with regard to the specific provision, steps that have been taken by the State to move toward compliance, obstacles that appear to be impeding the State from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served; and

(c) **Recommendations:** The Independent Expert's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the Settlement Agreement identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance. However, it is in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

In response to the parties' request and based on reviews in January 2012 of Beatrice State Developmental Center (BSDC) and in April 2012 of individuals that had resided at BDSC as of October 19, 2007 who now resided in the community, the Independent Expert proposed areas in which: a) less oversight is necessary from the Independent Expert Team due to progress the State has made; and b) focused efforts are necessary. On June 19 and 20, 2012, the parties met to review and discuss the draft list. A document was created that represented the parties' agreement with regard to priorities for implementation and the Independent Expert's review going forward. This document did not reflect the position of either party with regard to factual statements and/or compliance assertions contained within the document. As the Independent Expert and her team conducted this most recent monitoring review, the focus was on the areas identified as "Areas Requiring Focused Efforts." However, if the Independent Expert's Team became aware of problems with the implementation of a requirement(s) of the Settlement Agreement currently identified as "Areas in which Less Oversight is Needed," the review could be expanded to include the relevant requirement(s). In this report, the "Areas in which Less Oversight is Needed," and "Areas Requiring Focused Efforts" are in italicized gray print. The Independent Expert's Team's findings and information gained through the most recent review are in regular print. During the reviews since the parties met, based on the State's progress, the Independent Expert Team has identified additional areas that appear to require less oversight. As appropriate, the report identifies these areas, and the Independent Expert has made corresponding recommendations that these areas shift to this category.

IV. Executive Summary

As this report clearly shows, since the parties signed the Settlement Agreement, the State showed its commitment to implementation of the numerous requirements through various means, including staff effort, as well as requests and legislative approval of resources necessary to make systemic improvements. These actions have resulted in many improvements that have positively impacted the protections, supports, and services available to individuals at BSDC and the Bridges Program, as well as those individuals that transitioned to the community. In many cases, these improved processes resulted in better outcomes for individuals. The achievement of these goals has only been possible through strong teamwork and the dedication of many staff.

As part of this review, the United States asked the State to provide some updates to show some of the changes that have occurred since the time the United States completed its investigation of BSDC in 2007. On August 14, 2014, in a set of documents entitled: Division of Developmental Disabilities Updates (DDD Updates), the State provided the United States and the Independent Expert with such information in relation to the direct services provided through BSDC and the Bridges Program, as well as Community-Based Services. The State compiled information from a variety of sources, and provided some documents to support the summary information. This information was very helpful, and has been

quoted throughout this report. However, not all of the information the State provided has been replicated in this report, due to the fact that the United States had access to the same information the Independent Expert was provided.

As a result of improvements, over time, the parties agreed to the Independent Expert having less oversight responsibilities. In this report, numerous additional recommendations are included for less oversight. Due to the length of this report, it includes an Executive Summary that provides highlights of findings. In addition, for the convenience of the parties, Appendix B identifies the few areas the Independent Expert has identified that continue to require focused efforts. In all of these areas, the State is actively implementing plans to address them, and these plans are identified in the appendix as well.

As always, the Independent Expert Team would like to thank the State Office staff, as well as the management team, staff, community providers, and individuals served in the community and at Beatrice State Developmental Center for their professional and helpful approach to this monitoring visit. As is reflected throughout this report, staff provided the Independent Expert Team with information requested. The Independent Expert Team recognizes and appreciates the time and effort staff spent preparing for, participating in, and producing the documents necessary for the review.

Placement in the Most Integrated Setting and Community Supports

Since the United States completed its investigation in October 2007 and the Settlement Agreement was signed in July 2008, the State had taken a number of steps to increase community capacity, and improve its oversight of the community system to ensure that individuals the Settlement Agreement covers are provided the protections, supports, and services they require. When this Independent Expert joined the case in early 2010, the State was in the process of building much-needed infrastructure for the community system. Many of the pieces necessary for a healthy community system had either been missing or were not operating in a fashion necessary to meet the goals and the requirements of the Settlement Agreement. Through considerable hard work on the part of the Developmental Disabilities Division (DDD) leadership and staff, and recent efforts of the staff from the Division of Children and Family Services (DCFS), important changes had been made or were in the process of being made to improve access to the community for individuals from BSDC and Bridges and meet their needs, particularly individuals with complex medical and behavioral needs. These efforts required a systems-change approach, including a variety of initiatives, for example, modifying Home and Community-Based Waivers, rewriting and then enforcing regulations, adding clinical staff to the State Office team, developing and implementing training, recruiting providers, revamping practices, improving service coordination, just to name a few. The following summarizes some of these efforts and/or their results, as well as some of the areas that continued to require focused efforts:

- There had been a strong commitment to funding community services. According to the "Community-Based Services Expansion of DD Services" section of the DDD Updates the State provided: "Since 2007, the Nebraska Governor and Legislature have expressed a firm commitment to developmental disability services

through increased funding for the oversight and quality of services and also through the increased funding of the services themselves…" A summary of DD Historical Expenditures showed a 96.59% increase between Fiscal Year 2007-2008 and Fiscal Year 2014-2015 (i.e., from $72,918,405 to $143,352,195).

- Of note, in 2013/2014, although not a requirement of the Settlement Agreement, the State engaged in a substantial effort to address the rate methodology, requiring review of individuals' budgets to reduce funding for individuals that were overfunded, and increase funding for individuals that were underfunded. Reviews were conducted using an Objective Assessment Process. Based on information in the DDD Updates, this resulted in approximately 3,900 individuals receiving budget increases, and approximately 800 having decreases. Effective 7/1/14, nearly $36 million of state and federal funds were allocated to ensure proper funding of individualized budgets.
- As has been detailed in previous reports, since the inception of the Settlement Agreement, the State had worked to expand the community options available to individuals, including both residential and day/vocational opportunities. This had occurred through the expansion of the options available through Waiver-funded services, the development of small ICFs/ID, the expansion of the community provider-base in the State, as well as work with providers interested in changing their service delivery models (e.g., from a work center or day treatment model to programs offering vocational as well as other integrated options for activities). Based on the information the State provided in its DDD Updates, in 2009, there were 25 specialized providers (i.e., those certified under the 404 regulations to provide community services). Since then, 35 have been newly certified. Some of specialized providers are certified to provide supports in more than one location, resulting in a total of 87 certified programs. On an ongoing basis, the State assesses the need to add to the provider network.
- In the "Community-Based Services DD Waivers" section of the DDD Updates, the State noted that it primarily provides supports through two adult Medicaid Waivers and one children's Waiver. In addition: "In 2011… The Division revised its waivers to expand the services available to individuals in the community. The Division recognized the need to provide for more person-centered practices to allow people with developmental disabilities to work and participate in their communities as fully as possible." In 2015, the State Plan and HCBS Comprehensive Developmental Disability Waiver are due for renewal, and forums had been held and more were planned to gather input from stakeholders. In addition, on September 3, 2014, the State posted for public comment its "Transition Plan to Implement Settings Requirement for Home and Community-Based Services Adopted by CMS on March 17, 2014 for Nebraska's Home and Community-Based Services." Based on the Independent Expert Team's review, the following provide some examples of the positive results arising from the State's firm commitment to expanding capacity, sustained advocacy, thoughtful planning, and careful allocation of resources:
    - Many of the people with whom the Independent Expert Team met during the onsite visit spoke with gratitude about the work DDD had done over the last several years to transition them or the

individuals they served to more appropriate living situations. One woman (i.e., Individual #132) said the following about her community placement: "I love it… it's freedom. I'm enjoying my life!"
    - Another individual's team (i.e., Individual #232's) reported at his recent ISP meeting his sister said: "Our family never thought his life would be this full." His staff also stated how: "the BSDC staff was terrific helping with the transition."
    - Another team talked about how another individual (i.e., Individual #346) responded to the positive changes at Bridges: "All my dreams are coming true."
    - Individual #419 had just moved into the community from Bridges. He was thrilled to show the Independent Expert Team his new home. He was much closer to his family, and was really happy he was able to visit them twice a month.
- On 10/19/07, the United States completed its initial review of BSDC. Since that time, 353 individuals resided at the Facility. As of 3/14/14, based on data the State provided, the status of those individuals was as follows:
    - A total of 141 individuals were in settings outside of BSDC, including:
        - Of these, 97 (69%) individuals were living in small community-based developmental disability settings, or with family;
        - A total of 22 (16%) were living in other ICFs/DD, including 14 individuals who were living in small ICFs/ID (i.e., six-person ICFs/ID);
        - Ten (7%) were living in skilled nursing facilities in Nebraska, and one lived in an out-of-state nursing facility. Based on conversations with State staff, efforts were continuing to offer community-based options to individuals and their guardians. However, at the time of the Independent Expert Team's onsite review, none of these individuals were planning transitions;
        - Four (3%) were living out-of-state; and
        - Two were living in other settings (e.g., with family) (1%).
    - A total of 86 individuals had died. Since 3/14/14, an additional 10 individuals died, including two at BSDC, and eight in the community, including two in nursing homes.
    - Seven individuals were served in the Bridges Program, and since the last review, had moved to three State-operated community homes; and
    - At BSDC, 126 individuals remained. Seven individuals were in some phase of transition planning to move from BSDC to the community.
    - In June 2013, the individuals residing at Bridges moved from the residence on the campus of a mostly uninhabited former mental health hospital to secure homes in a community setting. In April 2014, the Independent Expert Team visited the seven men in the three four-bedroom homes that the State had constructed on a piece of land surrounded by farmland. The homes were licensed Centers for Developmental Disabilities, and certified to provide community-based specialized developmental

disabilities services. In stark contrast to the previous location of the Bridges program, the new homes were lovely and the individuals living there appeared to be benefitting from the transition to residences that allowed for more opportunities to learn and practice more independent living skills. Since the last review, one individual from the Bridges program also had successfully transitioned to live with supports from a community provider.

The homes were an example of the positive results arising from the State's firm commitment, sustained advocacy, thoughtful planning, and careful allocation of resources. Particularly within the confines of a state government structure, it was no easy feat to build these homes from the ground up, and put all of the necessary pieces in place to allow the men to move into the homes. Many steps had been taken to ensure the success of the program. With the leadership of State Office and hard work of many of the Bridges staff, community homes had become a reality for the men at Bridges. All of the staff involved should be commended for their work on this project, as should the men who played an integral role in the process. This coupled with the efforts described in previous reports to partner with a community provider to offer better vocational and volunteer opportunities for the men had substantially increased their integration into the community, while being ever-cognizant of the need to do so safely.

The DDD Updates summarized some of the outcomes the Bridges Program achieved since the inception of the Settlement Agreement. These included:

- Nine of the original 16 men transitioned to privately-operated community services;
- Since 2011, no psychiatric hospitalizations have occurred;
- Mechanical and programmatic restraints have been eliminated. In the first quarter of 2014, only six incidents of emergency safety interventions occurred, lasting one minute or less); and
- Psychotropic medication usage has decreased.

- With regard to expanding opportunities for employment and integrated activities for individuals supported in the community system, since 2007, the State had taken undertaken a number of important initiatives, and outcomes for individuals across the system appeared to be improving. Based on information the State provided:
  - "With the approval of the two adult waivers in 2011, employment services were revised to provide greater opportunities for individuals to explore integrated employment... providers are able to bill for more time spent on assisting individuals with seeking employment. Employment services are compensated at enhanced rates to encourage providers to provide these services."
  - Other steps the State had taken included, but were not limited to: in 2010, planning sessions were held to develop plans designed to achieve the goal of doubling the employment rate of people with

developmental disabilities in the next five years; in conjunction with the Developmental Disabilities Planning Council, the Arc of Nebraska developed a transition tool-kit that included a series of three videos recorded by the Division of Developmental Disabilities; the Division also assisted another DD Planning Council grantee [to] develop the Ready-Set-Go transition planning guide; and the same grantee also developed an online training program called Together we Can, geared towards non-specialized providers and offered a module on job coaching.

In terms of improved outcomes for individuals across the system, the State reported that based on a survey of Community Coordinator Specialists (CCSs):

- The number of individuals who were employed in an integrated setting increased from 18% to 23%. In 2013, 5% were working 20 or more hours per week, compared to 3% in 2007.
- The number of individuals who were volunteering in an integrated setting increased from 10% to 23%.
- The number of individuals who were participating in recreational activities in an integrated setting increased from 40% to 64%.
- For individuals the Settlement Agreement covers, as of April 2014, 17 (14%) were accessing employment services funding (i.e., competitive and/or supported, including two of these individuals working independently without staff support), and 107 (86%) had funding for community inclusion, volunteer, or day activities.

During this onsite review as well as previous reviews, the Independent Expert Team saw a number of examples of innovative vocational and day opportunities for individuals the Settlement Agreement covers. As indicated in this and the previous report, progress has certainly been made and continued encouragement from the State is warranted to support providers in extending to all individuals the Settlement Agreement covers who want to work, the opportunity to do so in the most integrated context possible.

- Transition planning was an area in which significant progress was seen over time. At the time of the most recent review, the State had developed and implemented a reasonable transition planning process. BSDC and Bridge's teams were expected to work closely with the community providers that individuals and their guardians selected to make the transition successful. They developed a transition plan that in conjunction with the Individual Program Plan (IPP) was intended to describe the protections, services, and supports the individual required, and the mechanisms through which these supports would be transitioned to the community setting(s). This was accomplished through a series of meetings and contacts, including the individuals making visits to proposed homes and day/vocational sites, and community provider staff visiting BSDC, and BSDC staff often accompanying the individual to his/her new home for a short period. Based on the Independent Expert Team's interactions with individuals, families, and community provider staff, these revised processes had resulted in much smoother transitions for individuals, largely because the information sharing had increased, and the IPPs in conjunction with the transition plans that individuals transitioned

with fairly comprehensively identified their needs for protections, supports, and services.

- After individuals transitioned to the community, an important requirement of the Settlement Agreement was oversight to ensure they were provided with the protections, supports, and services they required. As noted above, since the United States completed its investigation, much of the infrastructure of the community system had to be built or rebuilt. This included these oversight mechanisms, including survey and certification for Waiver services, as well as service coordination. Although some of the components of the oversight system were still developing, some positive outcomes for individuals had begun to be seen as a result of the identification of unmet needs, and the State's work with individuals' providers and teams to make changes to improve deficits identified. Some of the steps taken included:
    - Over time, a number of improvements had been made to the service coordination system, now referred to as Community Coordination Specialists (CCSs) for individuals the Settlement Agreement covers. As the State indicated in the materials it provided for the Independent Expert's previous review: "Prior to July 2008, service coordination was structurally under the Division of Child and Family Services and the Division of Developmental Disabilities had no supervisory authority. When service coordination was realigned back to the Division of Developmental Disabilities, it was discovered that the quality [of] services had been negatively impacted by inadequate training, unclear operational guidelines and direction, and inequity of caseload distribution. Since 2010, the duties and expectations of services coordinators have been revised to focus more on advocating for the individual and providing more person centered services…" As has been illustrated in the Independent Expert's reports, the State ensured caseloads consisted of no more than 25 individuals, developed a number of training resources for CCSs, ensured that their caseloads met those required by the Settlement Agreement, and made additional technical assistance resources available to Service Coordinators. Many CCSs were clearly very familiar with the individuals on their caseloads, and were playing a stronger role in the lives of individuals both in the community and at BSDC. They were involved in transition processes, IPP development, and monitoring activities.

      At the time of the last review, efforts were underway to modify the monitoring tool(s) CCSs used. In 2013, a QI Subcommittee was initiated with the task of developing and addendum to the existing monitoring form to better assess the supports and services provided to individuals with specific behavioral health or health needs. On 1/1/14, CCSs supporting individuals the Settlement Agreement covers began piloting the new tool, which included instructions. In April 2014, a second subcommittee was initiated to revise and update the general monitoring form all Service Coordinators use. Comments are provided in this report on the draft addendum. It is positive that the State was taking these steps, but additional work remained for CCSs to accurately monitor the

provision of services and supports individuals receive, and for the data to then be aggregated and analyzed, with corrective actions taken as necessary.

- Similarly, the Division of Developmental Disabilities overtook responsibility from the Division of Public Health (DPH) for certification of a number of the State's Home and Community-Based (HCB) Waiver services. New regulations entitled Title 404, Community-Based Services for Individuals with Developmental Disabilities, were approved, finalized, and issued on 7/16/11. These new regulations represented a substantial revision to the regulations related to HCB Waiver Services. [Under Title 175, Regulations Governing Centers for the Developmentally Disabled (CDD), DPH maintained licensing authority for CDDs, which are homes serving four or more individuals.] The Title 404 regulations are the standards on which monitoring for certification is based. The regulations include a number of important components that, if fully implemented, should assist DHHS in ensuring that individuals who have transitioned from BSDC to the community since October 19, 2007, have the protections, supports, and services they require. State staff were reviewing the regulations to determine if changes were necessary based on recent changes to federal and state requirements.

  Based on review of some recent reports, surveyors were identifying some important issues related to policies and procedures, implementation of administrative requirements (e.g., background checks), staff training, as well as the implementation of services and supports. As noted in the last report, overall, the extent and scope of the review was not always clear from the reports, because the reports included exceptions, as opposed to providing a summary of all of the survey team's findings. Anecdotally, however, the survey and certification efforts had identified some problematic issues both for individuals and on a systemic level, and had allowed the State to take action to improve some outcomes for some individuals.

- The Individual Personal Plans (IPPs) for individuals visited during this review did not consistently document adequate structured habilitation commensurate with their needs and preferences, or the level of resources invested in their supports. However, in 2013, the Qualified Developmental Disabilities Professional (QDDP) Support Services Team was created with a focus on community IPPs. This team included a supervisor and two program specialists. Along with the DOJ Transition Manager, the QDDP Support Services Team staff were working on revising the IPP process for individuals in the community by means of adding prompts to the IPP Template, and developing and implementing a revised IPP Checklist, guidelines, and a process for the review of IPPs. Community Coordinator Specialists reportedly were using the IPP Checklist as a training and self-assessment tool for community ISPs. The State also was continuing its implementation of a pilot person-centered planning process. These efforts represented promising approaches to addressing the weaknesses in habilitation planning for individuals in the community.

- As discussed in previous reports, a Medical Review Team consisting of the Chief Medical Officer of the State of Nebraska's Division of Developmental Disabilities and two nurses consulted with the teams of individuals in the community annually. They had made a number of recommendations, and processes were in place to follow-up on the recommendations. This included CCSs following up with teams to determine the status of recommendations, as well as to find out if there were questions about the recommendations. The Medical Review Team also had conducted a number of follow-up meetings with teams. Although some guardians had refused further involvement of the Team, a number of guardians had provided consent for the Team to contact individuals' physicians to further discuss the recommendations. Recommendations were related to a number of different issues, and addressed primary as well as specialty care, including psychiatry and behavioral services. Although follow-up to the team's recommendations were in various stages, some positive outcomes were seen in the documentation provided.
- With regard to nursing supports, during this review period, the Monitoring Team noted significant improvement of the nursing care in some community agencies, while inadequacies persisted in others. The Morality Review Committee reports continued to cite issues related to the availability of knowledgeable nurses and good nursing practices as well. However, the State had engaged in a number of efforts to ensure adequate supports and protections were in place and expand capacity, including the Nurse Specialists' review of individuals' nursing and medical supports, as well as CCS and survey and certification monitoring activities. In addition, the technical assistance activities of the Nurse Specialists were assisting the State in it efforts to improve community providers' capacity to provide appropriate nursing care and treatment to individuals with a variety of healthcare needs.
- In the last report, it was noted that the State provided training to a total of 265 community provider staff using a program entitled "Supporting the health and well-being of the person with IDD." The curriculum covered general approaches to identifying and responding to individuals' medical conditions and medical emergencies, but also went into some depth with regard to specific and commonly encountered medical conditions for individuals with intellectual disabilities. At the time of the current review, plans were underway to hold a conference entitled: "It's My Life." The three-day agenda for the conference showed a variety of sessions, including some a clinical tract as well as a behavioral tract. This was another example of the State's efforts to expand community capacity with regard to clinical competency, including nursing competencies.
- The dental clinic at BSDC could accept referrals from the community. Generally, these individuals had not been able to access dental services in the community to meet their specialized needs. For example, some individuals required more time to acclimate to the dental office. In addition, the BSDC dental Office could offer dental services under general anesthesia to individuals requiring it. The staff in the BSDC Dental Office had years of experience in working with individuals with intellectual and developmental disabilities, so it

was positive that this option was available to individuals that were having difficulty accessing community dental services.

- A significant concern noted in previous reports was that the community capacity for physical and nutritional supports (PNS) was limited. Since the last review, the State took some important steps to expand capacity. Specifically, an agency contracted with the State was coordinating the provision of statewide basic and advanced PNS courses. Beginning on May 2, 2014, the first of these courses, *Nutritional Assessment and Meal Planning for Individuals with Disabilities*, was scheduled for five different locations across Nebraska. The BSDC Director of Physical and Nutritional Supports and a BSDC Dietician were to present the training. This training was targeted for caregivers, provider staff, nurses, dieticians, dietary aids, quality assurance, and supervisory staff. Based on interviews with staff from the contracted agency, this was the first phase of PNS training to be provided in the community. Additional phases of training were being planned. Additional PNS training was scheduled for the *It's My Life* Conference, scheduled for September 2014.
- The planned training was a good start, but additional work will need to be done to expand the capacity of community clinicians and community provider staff to enhance their understanding of the need for the importance of providing comprehensive PNS services and supports to individuals, as well as communication supports. Community providers and CCSs continued to express their concerns with securing therapy services, and review of records showed a lack of assessments, and/or assessment of insufficient quality. Based on the sample of individuals reviewed, community providers were developing and implementing some components of PNS plans for individuals at high and/or medium risk, and this was a positive achievement. However, additional work was needed to ensure individuals at high and/or medium PNM risk were provided with comprehensive PNS plans that incorporated the necessary components. In addition, a number of individuals that had transitioned from BSDC to the community had unaddressed needs that would benefit from coordinated therapeutic and medical/nursing supports (e.g., involvement of a PNCS Team). The State, community providers, and other stakeholders should continue to collaborate in the development of a model and identification of a funding source(s) for a coordinated/integrated sustainable system for providing physical and nutritional services and supports.
- As noted in the previous report, the State had contracted with an agency to work with community providers to conduct 50 Functional Behavior Assessments (FBAs), and develop and train staff on Behavior Support Plans (BSPs) for individuals served by a number of providers around the state. The goal of this initiative was that individuals would have improved behavioral assessment and intervention services, but also that provider capacity to conduct these services independently would be improved in that staff members would gain expertise through participation in the process. While the initiative was slowed due to staffing changes at the contracted agency, the initiative had been re-started and continued at the time of the most recent review. Based on the most recent review of a sample of FBAs and BSPs, for some individuals, these supports were improved. These improvements often were a result of the contributions of the contracted personnel

from outside the provider agency. However, some FBAs and BSPs continued to be substandard and this finding emphasizes the need for continued technical assistance to community providers and continued efforts to increase the capacity for adequate behavioral assessment and treatment in the community. In the DDD Updates, the State recognized the need for ongoing training and technical assistance, and indicated: "the Division intends to offer monthly trainings through the end of 2014. The BSDC Team is developing an advanced-level training for people who have background in FBA and BSP. The advanced level training will address requests from provider agencies for the opportunity to gain practical experience in applying the knowledge gained during the first training session addressing several case studies while benefitting from professional guidance by the BSDC trainers."

- As has been discussed in previous reports, the State had previously run and now contracted with a provider agency to operate the Team Behavioral Consultation service. At the time of this review, the private agency continued to provide consultation to community providers to address the needs of individuals with significant behavioral challenges. The program was referred to as the Intensive Treatment Mobility Services (ITMS). At the time of the Independent Expert's last review, the provider agency had two groups of staff to allow coverage across the state, including the Omaha and Greater Nebraska offices. Since then, additional groups were added, and at the time of the most recent review, six teams were available, including three in Omaha, two in Lincoln, and one in Kearney. Consultations included efforts to build providers' capacity for behavioral treatment planning and implementation. A majority of individuals the program supported had a dual diagnosis of intellectual/developmental disability and serious mental illness. In a number of instances, this service appeared to assist individuals to maintain their services in community settings, while assisting community providers to improve the services they provided. Data from 2010 through 2013 showed that many individuals in the overall DDD system had benefitted from these services (i.e., in 2010, 108 referrals; in 2011, 72 plus referrals; in 2012, 71 referrals; and in 2013, services were provided to 93 individuals). In addition, the State indicated it was completing an additional incident review process that could lead to a referral to one of the teams, if needed.
- The provider with whom the State contracted the Intensive Mobility Services also operated an Assessment Center. Its capacity at any given time was three individuals. The purpose of the home was to provide a community-based assessment for individuals for whom this was not possible in their current home, and/or, in some cases, for individuals transitioning from a regional center or Bridges. It was not a long-term placement, but the contractor's staff supported the transition of individuals to their long-term placement through training and other supports.
- For individuals the Settlement Agreement covers, BSDC psychiatrists continued to follow some of them in the community, and community psychiatrists supported other individuals. As part of this most recent review, a sample of eight individuals prescribed psychotropic medication and supported by seven different community providers was reviewed. On a positive note, generally, community providers were sharing

behavioral data with the psychopharmacologists. However, less information about potential side effects was regularly shared, and review of provider's systems for collection and summarization of side effect information showed varying methodologies, some of which likely negatively impacted the quality of the data. In addition, although full documentation was not always available, as noted in this and the previous community report, questions continued to exist with regard to clinically justifiable, differential diagnosis; justification for the off-label use of medications; justification for intra-class polypharmacy; and follow-up. As noted in the last report, it was positive that the Medical Review Team had included some recommendations related to these issues in their reports, and that teams had begun to take some action to address these recommendations. However, the reviews were not identifying all relevant concerns, and follow-up was not consistently completed and/or documented.

- In calendar year 2013, 10 deaths occurred of individuals the Settlement Agreement covers, including one individual living at BSDC, three in nursing facilities, and six living in community settings. In 2014, thus far, 13 individuals died, including two living at BSDC, four living in nursing facilities, and seven in community settings. In April 2014, DDD provided the Independent Expert Team with a copy of a report entitled: "2013 Summary Information pertaining to Death of Individuals receiving Developmental Disabilities Community-Based Services." The report included a number of charts and graphs, as well as narrative breakdowns of some important data. This was a helpful first step in the analysis of data related to deaths. Necessary next steps include more in-depth analysis of the information. For example, analysis should be conducted to determine whether or not changes in practice might reduce individuals' risk. Such in-depth analysis is necessary to make the information meaningful and usable for providers, and so that as a system, the data can be used to identify areas in need of attention. Such analysis might lead to the development of action plans, and/or given the historical nature of some of the information, lessons learned that might impact future policy.
- Over the last year, DCFS continued to take steps to address concerns related to the need for a strong abuse, neglect, and exploitation system. In May 2014, DCFS was initiating a process to notify providers of the need to remove alleged perpetrators from direct contact with individuals, as well as to initiate investigations within the first day, when necessary. DCFS' commitment and efforts to make these changes was commendable. DCFS had a process in place to notify providers of the results of investigations. DDD and DCFS' relationship with regard to the conduct of investigations had developed over time, and at this juncture, both divisions' efforts appeared to have resulted in increased collaboration. Improvements were seen with regard to the quality of Adult Protective Services (APS) investigations, but this was an area that continued to require focused efforts, particularly with regard to the need for the use of sufficient methodologies and reconciliation of evidence to support the findings. DDD's complaint investigation process showed good improvement, including CCS' documentation of necessary follow-up. Since the last review, DCFS had

initiated QI Case Reviews of investigation reports, which should assist in identifying areas needing improvement.

Beatrice State Developmental Center

Since the inception of the Settlement Agreement, many positive changes had occurred at BSDC. The strong commitment to continuous quality improvement was evident both in the transformed processes and procedures necessary to make and sustain change, the outcomes for individuals, and the campus itself. Many of these are discussed in this report, as well as in a number of previous reports.

As noted in the last report, although changes to the physical campus of BSDC were not requirements of the Settlement Agreement, since the Independent Expert's first visited the campus, a number of important modifications had been made that resulted in a more normalized environment for those individuals who chose or whose guardians chose for them to live there. Some of these included: destruction of three unused buildings on campus (i.e., 400 Kennedy, 101 Kennedy, and 201 Carstens Drive), plans to demolish two additional buildings (i.e., 201 Sheridan in 2014, and 301 Kennedy in 2015), and the repurposing of buildings for storage only or to increase the number of people not affiliated with BSDC on campus and maximize space available for individuals living on campus; dismantling of an on-campus system of large trailers for transportation, and replacement with passenger cars or vans; a change from a central food service to kitchens in all the homes on campus, which allowed individuals and staff to take over responsibility for cooking meals; installation of laundry equipment in the homes; closure of the work center on campus and movement of those activities to a community site at which individuals could complete contract work at a central site, but also had options for community integrated employment or other activities; downsizing of the numbers of individuals living together in each of the campus homes, including providing most individuals with their own bedrooms; and remodeling buildings on campus that, although certified as an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID), were structured as apartments that provided individuals an opportunity to experience an even more independent living model. Although campus administrators and State Office staff clearly recognized that one of their key roles was assisting individuals to be more integrated in the larger community, efforts also had been made and were continuing to involve the larger community on campus. Some of these efforts included, for example: making the campus available to community groups and involving individuals in some of these activities, such as a musical presentation in the chapel to which the individuals on campus were invited, and youth groups and athletic groups that used the fields or other facilities on campus; leasing office space to other government agencies; renovating the café in which some of the individuals on campus worked and ate, and opening it to the public; and creating Bear Creek Shop, a craft store on campus that was advertised to the public at which a variety of art work and crafts that individuals supported at BSDC as well as other artisans had produced.

The following provides a summary of BSDC's status with regard to some of the Settlement Agreement requirements:

Protection from Harm

- Based on previous reviews, the Facility had processes in place to ensure that new employee and annual refresher training occurred on abuse and neglect and the related reporting requirements, including processes to test staff's knowledge, and track all staff's completion of the training.
- Based on previous reviews, a number of the components of investigations now required less oversight, such as their timely initiation and completion. For this review, focus was on the basis for the conclusions reached with regard to investigations of abuse and neglect, and the reconciliation of evidence. All 10 investigations sampled provided of an adequate basis for the findings and/or reconciliation of the evidence, which was very positive.
- Ongoing improvement was seen with regard to the quality of action plans resulting from investigations, including their thoroughness and the measurability of the action steps included.
- Since the beginning of the implementation of the Settlement Agreement, improvement had occurred with regard to the analysis of incidents and allegations. In addition to systemic review of incident data on a quarterly basis, the Quality Improvement (QI) Department had worked with the Incident Review Teams (IRTs) to increase the amount of relevant information available to conduct analyses. Facility staff also had worked to ensure that if analyses showed problems or trends related to incidents and allegations, action plans were developed to address them, or the rationale for either deferring action on them or not addressing them was included in the QI Quarterly Report. Given the various roads that analysis can take, Facility staff are encouraged to continue to ask the "why" question and expand analyses as necessary to identify root causes.
- A full review was not conducted this time, but it is worthy of note that the Facility's data continued to show decreasing trends with regard to peer-to-peer incidents of aggression. According to the 4Q13 Quality Improvement Report Executive Summary, dated 3/26/14, "With regard to Peer-to-Peer Incidents of Aggression, the target of 0% was not met for this quarter, but the results for this quarter (1.5%) and the 2013 average (2.53%) were both significantly bellow the baseline of 15% (from 3Q11). Significant efforts have been undertaken to reduce incidents of aggression between individuals supported by BSDC, and clear progress has been made. Efforts have included staff training, improved Behavioral Support Plans (BSPs) and implementation for individuals, and thorough review/root cause analysis when incidents occurred." The Independent Expert Team commends Facility staff for their commitment to and active pursuit of reducing risk in relation to peer-to-peer incidents of aggression. These efforts clearly have resulted in improved quality of life for individuals the Facility serves.

Staffing

- Based on information the State provided in its DDD Updates, since 2007, the ratios of staff in important positions had significantly increased. For example, in 2007, the ratio between direct support professionals

and individuals was .96, whereas, in April 2014, it was 1.71. In 2007, no Shift Supervisors were employed, and in April 2014, the ratio was .34 Shift Supervisor per individual served. Similarly, ratios for Primary Care Practitioners (PCPs), Psychiatrists, and Allied Health Professionals had improved significantly. The ratio of Behavior Analysts was 1:30 in 2007, and in 2014, was 1:14.

- In summary, as past reports have illustrated, over time, training at BSDC had significantly improved. In addition to comprehensive New Employee Orientation, which now included 40 hours of on-the-job training, staff were required to complete advanced courses, and training was available on an ongoing basis with resources, such as the Training Department and the College of Direct Support. Behavior Support Specialist and the Healthcare Coordinator positions now played an active role in providing "just in time" training in the homes, and helped to identify training needs. Supervisor training had been established and implemented. Since the last review, an area in which progress had been made was in the development and implementation of skills-based, and ability- or experience-based competency-based assessment for staff in a variety of areas. Such areas included behavior, healthcare, and physical and nutritional supports. Some work was needed to ensure necessary annual refresher training was defined for some of the clinical areas. However, overall, the progress in this area was notable, and appeared to have had a positive impact on the supports individuals at BSDC received.
- Numerous recruitment efforts were ongoing for both clinical and managerial positions, as well as direct support professional positions, and the Facility continued to implement new and creative ideas to recruit and retain quality staff. Reasonable efforts continued to reduce turnover, when it was not healthy turnover, and to reduce the use of overtime.

Quality Improvement

- The development of a comprehensive QI system was an area in which significant improvement had occurred over time. As noted in the last report, the Facility had demonstrated the ability to develop indicators addressing many aspects of the quality of the protections, supports, and services it offered individuals, including some outcomes related to their health, wellbeing, and independence. BSDC staff continued to review and revise these indicators with focus on the identification of valid measures, and implementation of measurement techniques that result in the collection of reliable data. This was important, because with the achievement of some goals, BSDC should begin to develop new measures to address other important aspects of the quality of protections, supports, and services, and as Facility staff had identified, ongoing refinement of existing measures was necessary. In its quality improvement efforts, BSDC was using a combination of monitoring/auditing and review of other data sources. Analysis of data had continued, and now with more historical data available, comparisons were being made across time. In-depth analysis with attention to the identification of root causes should continue to be a focus moving forward. At this juncture, the Facility had a variety of report formats that addressed the needs of various audiences. The reports summarized action plans implemented, and in a number of cases, data showed that the plans implemented had resulted in

improvements for individuals. Although as the Facility recognized, its quality improvement system was an ongoing work in progress, in terms of the requirements of the Settlement Agreement, BSDC had developed the basic QI structure needed to identify problematic trends in a number of areas, conduct analysis, take action to address suspected causes, and evaluate whether the actions were effective.

Training and Behavioral Services

- Overall, IPPs showed continuing improvement and generally met the requirements of the Settlement Agreement. IPP audits appeared to be contributing to the process of continuous quality improvement. Specific areas in which improvements were seen since the last review included: continued attention to the definition of which assessments needed to be completed and updated to inform IPP development in an individualized manner, incorporation of assessment recommendations into IPPs, definition of baseline data when new goals were implemented, improved identification in IPPs of formal habilitation plans that covered areas of importance to the individual and a wider variety of need areas, improved monitoring of treatment integrity for formal habilitation programs, and use of data in assessing individuals' progress. The ISP template now also referenced the location of the Safety Plan.
- Evidence was present to show that efforts to increase vocational opportunities for individuals were yielding positive results:
    - In the 4th quarter of 2013, 92% of employable individuals worked or volunteered five or more hours per week, compared to 63%, 76%, and 89% in previous quarters. When compared to 2012, this also represented an increase, when the percent ranged from 42% to 48%.
    - A community-based provider was serving and increased number of individuals living at BSDC (n=37), and was in the process of adding a new vocational services space with the hope of adding capacity for 20 more individuals. A second community-based provider supported approximately 19 individuals from BSDC. These partnerships offered individuals the opportunities to leave campus to engage in artistic activities, as well as work and volunteer opportunities.
    - Data in 4th quarter QI report indicated that, for 2013, 62% of individuals eligible for employment were "employed in the community." This compared favorably with data from previous years (2012 – 35%; 2011 – 24%; 2010 – 7%).
    - To further this goal, staff reported that additional vocational support persons were being hired and that position descriptions had been revised to allow them to follow individuals into community-based vocational placements. A total of ten staff persons had been designated as job coaches.
    - BSDC continued to expand opportunities for individuals to work in various departments, such as the Human Resources Department, the Training Department, and Carstens Cafe and the Snack Shack.
    - In March, May, and July 2014, consultants with expertise in vocational services and job coaching were working with BSDC staff.

- Of note, staff reported that the Facility currently had five BCBAs on campus (plus one behavior analyst intern), representing a pool of behavioral expertise that has substantially increased over time.
- During the last review, the Independent Expert Team noted that recently revised BSPs showed significant improvement in many of the areas previously identified as problematic. The peer review process for BSPs appeared to be functioning adequately and producing positive changes in the quality of recently developed BSPs. During this most recent review, the BSPs the Independent Expert Team reviewed showed continuation of these improved practices. In addition, the timeliness with which BSPs were updated, approved, and implemented, including competency-based training of staff also appeared to be solidly in place. Treatment integrity monitoring was ongoing, and was showing good results.
- Mechanisms appeared to be in place to ensure that adequate coordination was occurring between the Behavior Support Team and neurology and psychiatry, and improvement with regard to the integration of speech and language with behavioral therapies was maintained. Regular coordination with primary care physicians appeared to be weaker, suggesting a need for further effort by the Facility.
- As noted in the last report, improvements with regard to the Human Legal Rights Committee (HLRC) process, including more substantive discussions regarding restrictive practices and rights restrictions, had been sustained and extended. A more formalized system to ensure that changes the Committee requested were completed had been established and implemented, and processes were put in place to ensure that restrictive practices were reviewed and approved by the HLRC.
- BSDC was maintaining a list of individuals with highest behavioral needs using a generally reasonable approach, and most often, had provided the necessary increased level of intervention. For one individual in the "highest behavioral need" group that had experienced a number of restraints, the Independent Expert Team recommends obtaining external consultation.

Restraint

- The Facility is to be commended for marked positive changes in attitudes and practices with respect to responding to behavioral crisis situations. Data included in the DDD Updates showed significant declines in the use of restraint. It is important to note that although these declines were positive, as indicated in the analysis of medication for behavioral crisis intervention in the 4th Quarter 2013 QI Report: "The decline in the overall number of behavioral crises is due in part to the decline in census with individuals having challenging behaviors leaving BSDC… Other factors include staff training and utilization of Behavior Support Plans." Without an analysis that takes into consideration the census numbers and the acuity of the population served at various points in times, a direct comparison cannot be made and these numbers should be used cautiously. With this caveat, the following summarizes the use of restraint:
    - According to the DDD Update, 2008 yearly averages included 131.25 physical restraints (duration of 665 minutes), and 62 mechanical restraints (duration 4286 minutes). Similarly, 2009 yearly averages included 164.25 physical restraints (duration of 918.25 minutes), and 54 mechanical restraints

(duration 2668 minutes). Based on the same report, 2013 yearly averages included 9.75 physical restraints (duration of 47 minutes), and zero mechanical restraints (duration zero minutes).

- The 4th Quarter 2013 Quality Improvement Report indicated a continuing decline in instances of restraints (eight instances for the quarter, compared to 22, nine, 11, and 11 in the preceding four quarters). A similar decline over the past year was noted in the number of individuals experiencing restraints. Only one individual used physical restraint in the 4th quarter for a total of 67 minutes. The Report documented zero instances of use of mechanical restraint, and zero instances of use of chemical restraint in the year 2013. However, a separate document included a log of one-time [psychiatric] medication in instances of behavioral crisis. Over the previous six months, there were six instances, three of which involved one individual. One individual required the use of medical restraints in 2013, 11 times in the six months before the review. This medical restraint is necessary due to a painful procedure that the individual undergoes regularly to prevent infections and maintain his wellbeing. The BSDC Human and Legal Rights Committee reviewed and approved the restraints.

Psychiatric Care

- As noted in the last report, psychiatric care at BSDC was an area in which significant improvement had been achieved over time. As a result, during this most recent review, limited areas that had been identified as requiring focused efforts were reviewed. Some of the areas in which progress had been made over time resulting in less oversight from the Independent Expert Team included: development and implementation of psychiatric treatment plans; regular review of such plans, and modifications as necessary; incorporation of behavioral data into the decision-making process; coordination between psychiatrists and other practitioners; reduction in the use of and/or justification for the polypharmacy, off-label use of medication, benzodiazepines, and use of typical antipsychotics; and ongoing attempts to manage individuals on the lowest necessary dose of psychiatric medications.
- At the time of the last review, an area in which progress was made, but more work was needed related to informed consent for the use of psychotropic medication. At the time of the current review, although most of the records reviewed did not have the benefit of the more recent side effect information BSDC was providing to guardians, it appeared from examples provided, as well as interview with staff that the new process addressed the concerns articulated in previous reports. It will be important for BSDC staff to continue the efforts begun in this area to ensure sufficient information, including information related to side effects, is provided for medications newly prescribed, and for medications individuals are already prescribed to allow individuals and their guardians to make fully informed decisions.
- The BSDC Treatment Team, which was made up of the treating psychiatrist and various members of the BSDC psychology team, had been meeting essentially monthly, discussing between ten and fifteen individuals per meeting. The goal of the meetings was to clarify and "clean up" all individuals' psychiatric diagnoses in preparation for a transition to DSM-5. Based on review of related documentation, it appeared that the BSDC

and Bridges psychiatrists were paying close attention to the diagnostic criteria when making diagnoses, which potentially was also having a positive impact on treatment.

Healthcare and Related Services

- Since the implementation of the Settlement Agreement, BSDC instituted a Neuromuscular Clinic, known and as the Spine and Gait Clinic. As the DDD Updates indicated: "…the Spine and Gait Clinic has evolved into a stand-alone, multidisciplinary clinic from which clinical solutions to complex anatomical and musculoskeletal conditions arise. Through the education and exposures of BSDC staff to recent bio-scientific theories and developments, the complicated clinical scenarios of brain, behavior, and body that characterize [BSDC's] aging population can be approached systematically and coherently." Over the course of the Independent Expert Team's reviews, examples were seen of how the resulting interventions significantly improved outcomes for individuals.
- Nursing was also an area in which improvements had been seen over time. Based on a sample of nursing care plans, they aligned with individuals' health care needs as defined in their histories and physicals, and provided more detailed guidance regarding the supports individuals needed from nurses as well as direct support professionals. In addition, documentation was provided showing competency-based education of these plans for the direct support staff. The revised nursing care plan format clearly delineated the Direct Service Professionals' responsibilities in care delivery.
- Health Care Coordinators continued to play an important role. Reportedly, they were assisting with the communication between medical and nursing staff, and the direct support professionals, for example, with regard to changes in status.

Nutritional and Physical Supports

- The provision of physical and nutritional supports (PNS) to individuals with identified needs was an area in which significant progress had been made since the Settlement Agreement was issued. At the time of the most recent review, the Facility continued to develop, revise, and implement a sustainable system for the provision of such supports. As noted in the last report, this system had been memorialized through the development and implementation of Physical and Nutritional Support Procedures, and Facility staff continued to update these procedures, as appropriate. In addition, PNM audits were being conducted on a quarterly basis to assess the effectiveness of PNS-related services and supports. The audit results allowed the Facility to confirm whether or not established procedures were being followed. When an indicator fell below the agreed upon threshold, the Facility had developed and implemented an action plan to address it.
- As noted in the last report, the procedures developed and subsequent revisions to the Physical and Nutritional Consultation Services (PNCS) process had a significant positive impact on the PNS supports provided to individuals on the PNCS caseload. Necessary improvements had been made with regard to PNCS assessments/action plans and their implementation. The following provide examples of positive outcomes for individuals:

- The PNCS Team continued to conduct Status Change meetings. This consisted of a review of several pieces of information, such as overnight nursing reports from the ICFs, medical consultation reports, and POS monitoring results, to name a few, that alerted the Team to individuals who might be in the early stages of experiencing a change in status. The PNCS Team had successfully transitioned to intervening more proactively with individuals and providing timely PNS services and supports. For example, the PNCS Team reported that the incidence of respiratory illnesses had significantly decreased from year to year. The PNCS Team attributed the decrease in respiratory infections to the effectiveness of the implementation of combined PNS supports and staff implementation of these supports.
- On a very positive note, four members of the Physical and Nutritional Consultation Services (PNCS) team (i.e., PNCS Director, PNCS OT, and two PNCS RNs) presented *OT Expertise in Interdisciplinary Physical and Nutritional Support for Developmental Disabilities* at the National Occupational Therapy Association Conference in Baltimore, Maryland. The members of the PNCS team presented an individual's success story and how the provision of physical and nutritional supports had impacted the quality of his life in a variety of positive ways. This individual had experienced issues with maintaining his weight stability, complained of abdominal discomfort, had a diagnosis of gastroesophageal reflux disease (GERD), had a diagnosis of dysphagia, and had been diagnosed with pneumonia in 2010 and 2013. This individual had been assessed by the PNCS and a PNS plan had been developed and implemented to address his PNS concerns. After receiving these services and supports, this individual continued to maintain his independence at mealtimes, was working toward being more independent by learning to use a power wheelchair, was able to assist with activities of daily living, and had not had any illnesses in over 12 months. This presentation provided the opportunity for the PNCS team members to share their experiences on a national level with other clinicians, but most importantly provided specific examples of how one individual's life had been significantly impacted in a positive way by receiving comprehensive physical and nutritional supports.

- The Facility had continued to implement its process for evaluating and/or marking the degree of elevation determined for each individual requiring such supports, which was very positive. Individuals were prioritized for elevation evaluations based upon presence of enteral feedings, medical referrals, or a high score on PNM 40 Question screen. Since the last review, the resulting information was consistently incorporated into relevant components of individuals' plans.
- As noted in the last report, the Facility's policies, procedures, and competency checklists provided a sustainable system to test staff competency in lifting, transfers, wheelchair positioning, alternate positioning, oral care, mealtimes, ambulation/mobility, and other therapy-related devices and/or techniques.

- As noted in the last report, the Facility had addressed in its procedures a process for formally assessing individuals who receive enteral nutrition annually, prior to the IPP meeting, for the appropriateness of receiving enteral feeding, justification to continue receiving enteral nutrition, strategies to transition an individual to a less restrictive approach, and/or transition the individual to oral intake, if appropriate. Since the last review, therapists were working to expand the provision of oral motor therapy from two times per week to three to four times per week, and in addition, to implement these programs during oral care.
- The Facility now had adequate templates, including guiding questions, and policies related to the completion of OT/PT worksheets and comprehensive evaluations. Based on a review of a sample of recent assessments, they included the necessary components.
- Based on information in the DDD Updates, approximately 30% of BSDC residents participate in formal therapies to improve positioning and ambulation. With regard to the development and implementation of OT/PT direct intervention plans, the Facility continued to make progress. It had revised and/or developed new procedures and guidelines to memorialize the process therapists should follow as they developed and implemented direct therapy intervention plans. Based on a review of direct therapy plans, they included measurable objectives, therapy plans were discussed in the individuals' IPPs, therapists attended the IPP meetings, skill acquisition programs or other methods of generalizing the skills individuals were learning through direct therapy were included in individuals' IPPs, and therapists completed progress notes.
- The completion of work orders related to adaptive equipment was being tracked. Since the last review, OT/PT procedures had been developed and implemented to define the expectations for the timely completion of work on wheelchairs and adaptive equipment and/or define the priority system for repairs.
- The Facility continued to be committed to expanding the number of individuals who received therapeutic positioning in multiple environments. As of 4/8/14, 46 individuals were provided therapeutic positioning in their residences and/or day programs. This was positive for individuals and helped to minimize and/or reduce their risk factors.

Communication

- As noted in the last report, the SLPs had made major positive revisions to the SLP assessment format, especially in the area of Alternative and Augmentative Communication (AAC) assessment. Since the last review, the number of individuals provided direct therapy continued to increase. Based on a review of a sample of assessments, the quality of recent speech and communication assessments was consistently good.
- In addition, individuals' AAC systems were integrated into IPPs, and provided strategies for individuals' AAC systems to be available and utilized in multiple environments.
- As noted in the last report, POS plans for AAC devices had been developed, which was a positive addition. These plans included a picture of the AAC system, defined when the individual should have access (e.g., during all waking hours), how the individual carried the system (e.g., pocket, purse, mount, etc.), habilitation

plan goal, how to maintain the system, troubleshooting tips, and when to notify the SLP. Competency-based training also had been provided to ensure staff knew how to use and assist individuals with the devices.

SECTION A: Reasonable Safety, Protection from Harm

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - Beatrice State Developmental Center organizational chart, undated;
  - Map of Facility, dated 3/13/14;
  - Community Day Services, March 2014;
  - An alphabetical list of all individuals served, including age, date of admission to Beatrice State Developmental Center, guardianship status, name of residence/home, and day/vocational program;
  - Beatrice State Developmental Center Census/Movement from 10/19/07, updated 3/14/14;
  - A list of vacancies, including the title and date of vacancy, as of 3/26/14;
  - For direct support professionals, the number of budgeted positions, the number of direct support professionals, the number of unfilled positions, the annualized rate of turnover, and the annualized rate of overtime;
  - In response to request for any changes to BSDC Training Plan, the response that there were no changes;
  - Between 1/1/13 and 12/31/13, and separately, for the months of January 2014 and March 2014, the total number of reportable incidents, the total number of serious reportable incidents, and the total number for each category of reportable and serious reportable incidents;
  - For the one week prior to the onsite review, for each ICF/ID, minutes of the IRT, including those for State Building, State Cottages, Sheridan Cottages, Solar Cottages, and Lake Street;
  - Incidents/Injuries by individual, for last one year-period;
  - 2014 Abuse Neglect Log, updated 10/15/14;
  - Fourth Quarter 2013 – QI Indicator Dictionary, updated 3/28/14;
  - Quarterly QI Report for the 3rd Quarter 2013;
  - Quarterly QI Report for the 4th Quarter 2013;
  - Fourth Quarter 2013 Quality Improvement Report: Executive Summary, dated 3/26/14;
  - For the last six months, a list of any formal plans of correction, including their status;
  - Pilot Retention Program for 2nd Shift Developmental Technician Staff at BSDC, January 2014;
  - Set of questions Human Resources staff use to interview staff as part of exit process at separation;
  - Policy #2.7: Incident Management, effective date 11/15/13;
  - Policy #2.2 Abuse/Neglect Policy, effective date 2/21/14;
  - Qualified Developmental Disabilities Professional (QDDP) Coordinator Status Update, revised;
  - QDDP Support Services – Quality Improvement Team, dated 12/1/13;
  - Fading Process for QDDP Document Review Guidelines, updated 3/31/14;
  - Updated QDDP Checklists; and
  - Reports for the following investigations: AN-14-004, AN-14-010, AN-14-016, AN-14-019, AN-14-023, AN-14-026, AN-14-031, AN-14-032, AN-14-034, and AN-14-035.
- **Interviews with**:
  - Lloyd Haight, Deputy Chief Executive Officer (CEO) for Indirect Services;
  - Brad Wilson, Compliance Team Manager;
  - Becky Agan-Mencl, Human Resources (HR) Manager;
  - Jennifer Monroe, HR Regional Manager;
  - Loree Rix-Crouse, Training Manager;

- Delvin Koch, Chief Executive Officer (CEO); and
- Alecia Stevens, QDDP Coordinator.

SECTION A: Reasonable Safety, Protection from Harm		
#	**Provision**	
Principal Requirement		
A1	The State has declared that the most important concern of the State Department of Health and Human Services is the safety and quality of life of its clients with developmental disabilities. To this end, the State agrees to provide residents with a reasonably safe and humane living environment which includes that the State shall: (1) protect residents from abuse and neglect; and (2) take effective steps to minimize or eliminate resident injuries and other significant incidents that may negatively impact their health, safety, and welfare.	*As the principal requirement, adequate implementation of this section is dependent upon the State addressing the remaining subsections of Section A.*
Zero-Tolerance for Abuse and Neglect		
A2	The State shall take effective steps to ensure that residents are free from abuse and neglect. The State has announced, and shall maintain, a policy of "zero-tolerance" for abuse (including verbal, mental, sexual, or physical abuse) and neglect, whether from other residents or from staff.	*With regard to the State taking "effective steps to ensure that residents are free from abuse and neglect," the other subsections of Section A related to implementation of the "zero tolerance" policy address this requirement.* *<u>Areas in which Less Oversight is Necessary</u>* ▪ *Maintenance of a "zero tolerance" policy – Based on the last version of BSDC's Abuse/Neglect Policy, effective date 1/31/12, it clearly defined abuse, neglect, and exploitation. It also included requirements regarding the implementation of immediate safeguards to protect individuals, internal notification processes, external notification processes (e.g., Adult Protective Services, and guardians/family members), the involvement of law enforcement, as appropriate, and the investigation process. In addition, the latest version of the policy clarified that any substantiated act of abuse, neglect, or mistreatment would result in termination of the employee, as would failure to report witnessed acts of abuse or neglect. These were important changes that supported BSDC's commitment to "zero tolerance" for abuse and neglect.*

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A3	The State shall provide effective, ongoing competency-based training to staff on recognizing and reporting potential signs and symptoms of abuse and/or neglect, and on the prevention of abuse and neglect of residents by staff. Such training shall include providing staff with an explanation of the definitions of resident abuse and neglect, explaining to staff that abuse and neglect are prohibited, explaining to staff the requirement to promptly report any suspected abuse or neglect, and advising staff of the potential consequences if they commit abuse or neglect or fail to promptly report witnessed or suspected abuse or neglect.	*Areas in which Less Oversight is Necessary* ▪ *Effective training - Although at the time of the January 2012 review, BSDC staff were continuing to seek out additional resources for training on abuse and neglect, the curriculum in place clearly stated BSDC's "zero tolerance" policy in easy-to-understand terms, including the consequences for engaging in abuse or neglect. It made clear the responsibility for staff to identify potential abuse, neglect, or exploitation; intervene to stop it; and report it immediately by talking directly to a supervisor and then calling APS, or calling the switchboard and calling APS. In addition, the training included information about the background check, and investigation and related follow-up processes. The training provided valuable information about signs and symptoms of abuse and neglect. It used scenarios that appeared would assist staff in identifying abuse and neglect, as well as responding to it.* ▪ *Effective training - The policy required annual refresher training for: "Any person who is providing service, care or support to an individual residing at any of the ICF facilities on the BSDC campus…"* ▪ *Effective training - Staff's responsibility was further reinforced through announcements that were hung in homes and day programs throughout campus, reminding staff of BSDC's zero tolerance policy, as well as the responsibility to report suspicions or knowledge of abuse or neglect to the Shift Supervisor and APS.* ▪ *Competency-based – The most recent version of the training included a post-test. The post-test had been revised, and covered important concepts from the training. In order to pass, a staff member needed to provide correct answers to all 15 of the questions.* *Areas Requiring Focused Effort* ▪ *At the time of the Monitoring Team's review in January 2012, the revised policy and training was about to go into effect. It was anticipated that all staff would be trained/have annual refresher training in the following couple of months. It will be important to ensure that this occurred.* As noted in the Independent Expert Team's previous report, during orientation and on an annual basis, staff were provided training on abuse and neglect and were required to complete a knowledge-based test at 100% in order to pass. In addition, as noted in the previous report, when changes occurred to the abuse and neglect policy, staff were required to complete training. Previous review of the training materials showed they included much relevant and important information, including a significant focus on recognition of the signs and symptoms of abuse and/or neglect, factors that might contribute to abuse and neglect, intervening and reporting requirements, the consequences of not reporting, and the prohibition on retaliation and steps that could be taken if it occurred. The Training Department also regularly reviewed and revised training, including addition of relevant scenarios. As a result of these firmly established processes, the Monitoring Team identified this as an area in which

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		less oversight was needed.
Adequate Staffing		
A4	The State shall maintain sufficient numbers of adequately trained professional and direct care staff on each shift to provide adequate protections, supports, and services to residents at all times.	*With regard to BSDC having "adequately trained professional and direct care staff," training is addressed with regard to Section A6, as well as various sections of the Settlement Agreement (e.g., A3 for abuse and neglect, C64 regarding competency-based training on behavior support plans, C78 on the proper use of restraints, C88 on training for staff completing side effect monitoring, and D114 related to competency-based training for nursing staff).* *Areas in which Less Oversight is Necessary* ▪ *Generally, the State and BSDC staff were taking numerous steps to fill vacant positions, including clinical, management, and direct support professional positions. Based on minutes and discussions with staff, Human Resources staff continued to work with BSDC staff to identify areas of need, and develop creative solutions to fill vacancies, such as options to increase applications, different work schedules, etc. The Facility's increasing use of data to identify areas of need, and reasons for turnover, etc. should be helpful.* *Areas Requiring Focused Effort* ▪ *Due to the impact on compliance with other sections, BSDC should make continued efforts to recruit quality staff to fill clinical positions, as well as direct support professional positions. This was an ongoing challenge, and as noted below, BSDC staff were actively working on it. Maintenance of effort as well as continued efforts to creatively address particular areas of need (e.g., second shift residential staff, doctorate level psychologists, behavior analysts, Physical Therapists, etc.) will be important.* In previous reports on BSDC, the Independent Expert Team detailed a number of steps the Facility was taking to fill open positions. These were ongoing, and will not be repeated in this report. In sum, the Facility continued to employ basic recruiting techniques, and was constantly identifying additional innovative practices to recruit qualified direct support professional staff, as well as clinical and managerial staff. In response to the Independent Expert Team's document request, the Facility provided information for the 3rd and 4th Quarters of 2013. According to this documentation, from July through December 2013, the number of full-time equivalent (FTE) positions available for direct support professionals (DSPs) was 312, of which on average 231 were filled, leaving 81 unfilled. However, the Facility indicated that it was actively recruiting for 94 of the vacant positions, including 16 on first shift, 45 on second shift, 15 on third shift, and 18 part-time/flexible schedule positions. In its written materials, the Facility indicated: "Due to the high number of vacancies on 2nd shift, we have

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		implemented more flexible scheduling and are trying to include more attractive days off for second shift positions, (i.e. every other weekend off). Additionally, we have implemented a Second Shift Retention Plan for staff on 2nd shift which would provide for up to $1,000 more in annual earnings for remaining on 2nd shift. We implemented the program February 1, 2014. As the census declines, we continue to evaluate staffing needs." Based on review of the Pilot Retention Program: For 2nd Shift Developmental Technician Staff at BSDC, existing second shift employees as well as new hires and transfers to the second shift were eligible for the incentive. Review of data was built into the program to evaluate its impact. This program illustrated the Facility's recognition of the issues around maintaining qualified staff on the second shift, and its ongoing efforts to resolve the issue to the extent possible. As reported in previous reports, the average turnover rate of direct support professionals between July 2009 and June 2010 was reported to have been 6.9%. During the period between July 2010 and December 2010, there had been an increase in the turnover rate to 10.1%, which had remained relatively constant through July 2011. Based on data the Facility provided for the period from January through June 2012, the average turnover rate for these months was 17.52%. Based on data for the period between October 2012 and March 2013, the annualized rate of turnover was 11%. For the period between July and December 2013, the annualized rate of turnover was 17% (with a range of two to 10 direct support professionals leaving monthly). As discussed in previous reports, turnover occurred for both positive and negative reasons. For this field of work, these turnover rates remained relatively low, and would be expected to fluctuate somewhat. As indicated in previous reports, BSDC had processes in place to track and analyze the reasons for turnover to determine if particular problematic issues were the cause. Based on interview with HR staff and ICF Administrators during the most recent onsite review, efforts were ongoing to identify reasons for staff leaving, and to try to address them before separation occurred. For example, when staff indicated they needed to leave to accommodate family or school schedules, efforts were made to identify part-time or flexible schedules that would work for both the Facility and the staff involved. Sometimes, these efforts were successful in maintaining a staff member. When staff did leave, supervisors identified the reason why, and a link to the DHHS exit survey was sent to the employee. In addition, HR staff now tried to meet with each exiting employee to ask a set of standard questions. Based on review of the set of questions, they appeared helpful in identifying potential issues, if any, that the Facility could address. As noted in previous reports, HR staff and the ICF Administrators continued to review turnover at weekly meetings, and they reviewed the reasons to determine if it could have been prevented. These were good practices. As during the previous review, BSDC staff were actively engaged in a variety of activities designed to fill clinical and managerial, as well as direct support professional positions. BSDC was taking reasonable steps to recruit and retain quality staff, and to analyze reasons for turnover in staff.

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A5	On or before November 1, 2008, the State shall maintain sufficient staff in direct care positions so as to minimize or eliminate the use of overtime to meet resident needs. The State may address staffing issues by hiring additional staff and/or by reducing the resident census at BSDC. In order to address staff fatigue, the use of mandatory overtime and requiring that staff work double shifts (two consecutive eight-hour shifts) is disfavored. In order to increase continuity of care and the familiarity of staff with particular residents and their needs, the State shall minimize or eliminate the use of part-time "on-call" staff and "pulled" staff who are unfamiliar with the residents on a unit.	*Areas in which Less Oversight is Necessary* ▪ *Use of "pulled" staff – Based on staff interviews, the use of pulled staff had been prohibited at BSDC. With the reorganization of the campus into five separate Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/ID), staff, including supervisory staff and direct support professionals had been assigned to each designated ICF/ID. Daily staff assignments would remain within the designated area or neighborhood, and staff were not reassigned or "floated" to other areas across the campus.* ▪ *Use of "on-call" staff: There continued to be a pool of "on-call" staff to ensure coverage for each of the ICFs/ID. However, these staff were assigned to each of the ICFs/ID, and could only be assigned to work within the ICF/ID to which they were assigned.* *Areas Requiring Focused Effort* ▪ *Minimizing Use of Overtime, including Mandatory Overtime – Given that overtime use has continued to increase, this is an area regarding focused attention. The Monitoring Team has offered recommendations, including:* ○ *Within the context of the labor union contract, establishing maximums for weeks or pay periods;* ○ *Analyzing data, including reason for overtime, and if certain homes on campus have particularly high overtime, determining the reasons why and addressing them. This should include determining if mandatory overtime was particularly problematic in certain homes;* ○ *Considering staffing up past the minimum ratios; and* ○ *Recruiting efforts are covered/discussed under Section A4.* On a positive note, use of overtime had decreased and stabilized. The most recent data for the time period between 7/1/13 and 12/29/13 showed an annualized rate of overtime of 11%. To provide a historical perspective, as noted in the previous report, data for the time period between 12/17/12 and 3/24/13 showed an annualized rate of overtime of 11.5%. The data for January 2012 through June 2012 had shown a slight decrease in the percentage of overtime to 14.83% of the total hours worked. Based on data for the time period between September 2011 and December 2011, the percentage of overtime of the total hours worked for direct support professionals was 16.43%, which was a slight increase from the 15.76% for the period between April 2011 and June 2011. In previous reports, the data the Facility provided showed that between July 2010 and December 2010, the average rate of overtime for direct support professionals was 12.94%. This was an increase from the period between July 2009 and June 2010, when the average was 9.78% of the total hours worked. In previous reports, a number of initiatives the Facility had taken to control to the extent possible the use of overtime were described. It was positive that such efforts were continuing t. For the past three reviews, a decreasing trend in the use of overtime was seen. Although the use of overtime will always

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		require vigilance, over time the Facility had put a number of processes in place to attempt to control it.
A6	The State shall ensure that residents receive all protections, supports, and services from staff who are properly trained on how to meet their individualized needs. The State shall place a heightened focus on ensuring that part-time "on-call" staff and staff pulled from other units are properly trained on individualized resident needs before assignment to any particular unit.	*This represents an overall training requirement. Other portions of the Settlement Agreement also require that staff complete specific training. As such, the overall requirement is addressed here, and in other sections training also is addressed (e.g., A3 for abuse and neglect, C78 on the proper use of restraints, C88 for staff responsible for completing side effect monitoring, D103 on recognition and management of seizures, and D114 related to competency-based training for nursing staff).* *Areas Requiring Focused Effort* ▪ *At the time of the January 2012 review, the Facility shared a recent draft of a training plan. It had not been finalized, and implementation was just beginning. However, it represented a comprehensive training plan to meet the requirements of the Settlement Agreement. As the training plan envisioned:* ○ *Staff should continue to focus on the development and implementation of competency-based training for direct support professionals to ensure they have the ability to implement individual-specific plans with fidelity.* ○ *Monitoring should occur to ensure that the competency-based goal of the training is met.* ○ *Expectations should be defined, and other professional and clinical staff should complete additional training commensurate with their duties, including QDDPs, psychology staff, and nurses.* As noted in the last report, Facility staff had taken many steps to strengthen the training provided to BSDC staff. To summarize, based on findings from past reviews: ▪ Since implementation of the Settlement Agreement began, BSDC had restructured and expanded its Training Department. In addition to a Training Manager and Training Specialist position, the Department also partnered with other departments to bring clinical expertise into the training. Some courses required a clinical trainer (e.g., the nurse's aide licensure course), but for others, clinical staff were involved in training the Training Specialists through a train-the-trainer process, and then, the "expert" performed competency checks to ensure the trainer had developed and maintained the required expertise. ▪ The BSDC policy on Staff training clearly set forth staff and their supervisors' roles in ensuring staff completed required training. It also appropriately defined the various types or levels of competency-based training, including knowledge-based competency, skills–based competency, and ability- or expertise-based competency. It further defined a reasonable process should staff not be able to demonstrate competencies required for their positions, or failed to demonstrate them when interacting with individuals. ▪ The Facility had a Training List that identified a number of important training courses. ▪ New Employee Orientation had been significantly expanded. As discussed below, efforts continued to improve this initial training provided to staff.

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		▪ New staff were expected to complete advanced training over the six months after they completed new employee orientation. This included a number of topics, such as behavior supports beyond what was provided in new employee orientation, active treatment, physical and nutritional supports, food safety and handling, etc. ▪ Behavior Support Specialist and the Healthcare Coordinator positions now assisted in assessing treatment fidelity, provided "just in time" training, and helped to identify training needs. ▪ Training Profiles were available through Therap. They profiles allowed training to be tracked for each staff, including assignment date, certification date, expiration date, and due date. The format allowed general training (e.g., annual training on abuse and neglect) as well as individual-specific training (e.g., training on a specific person's dining plan) to be captured. Based on staff report, Staff Assistants could pull these reports, as well as Investigators. Since the last review, based on interview with the Training Manager: ▪ New Employee Orientation continued to include an on-the-job training component using checklists, which were helpful in ensuring that specific topics were covered during the various times that new employees were in the on-the-job component of orientation. The on-the-job component now consisted of 40 hours. ▪ At the time of the last report, the State had signed a contract with the College of Direct Support, and BSDC was in the process of making decisions about how best to implement it at the Facility. Since that time, staff reported that approximately 100 direct support professionals had used it. The College of Direct Support offered hundreds of courses, which could be individualized to ensure they used terms and referenced policies consistent with those used at BSDC. Generally, course selections were made based on the interests of the direct support professional, as well as specific needs identified through supervision, investigations, etc. Based on staff report, all employees were given an hour of paid time per week for to take advantage of such training. ▪ Since the last review, all supervisors that had not previously completed the DHHS Supervisor/Manager training curricula, which was updated in 2009, completed it, and it was incorporated into new employee orientation for supervisors. In addition, since the last review, Facility staff made significant progress with regard to competency-based training related to staff's implementation of clinical treatment plans. Specifically, as discussed with regard to Sections D92, D110, and D114, competency-based training was now occurring for nurses, as well as direct support professionals related to the implementation of health care plans. In addition, as is discussed in relation to Section C64, and D126, competency-based checks were regularly occurring with regard to BSPs, and competency-based training had been established for staff on Point of Service (POS) plans, respectively. As the Training Manager recognized, annual refresher training was needed for the physical and nutritional management competencies. Overall, this showed good progress in this area, which in the previous report was identified as a final area requiring focus in relation to training.

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		Although not related to compliance for this section, of note, the Training Department: ▪ Had hired some individuals that resided at BSDC. Since the last review, this had expanded to include approximately six individuals. Some participated in greeting new hires, others participated in training (e.g., role playing or competency-based exercises with new hires), and one individual shared her personal story at quarterly training for Service Coordinators. Staff were working with individuals to expand their involvement, such as expanding communication alternatives and increasing computer skills; and ▪ Continued to discuss with State Office system-wide training opportunities for community-based staff, as well as the use of BSDC staff to provide specialized training. In summary, as past reports have illustrated, over time, training at BSDC had significantly improved. In addition to comprehensive New Employee Orientation, which now included 40 hours of on-the-job training, staff were required to complete advanced courses, and training was available on an ongoing basis with resources, such as the Training Department and the College of Direct Support. Behavior Support Specialist and the Healthcare Coordinator positions now played an active role in providing "just in time" training in the homes, and helped to identify training needs. Supervisor training had been established and implemented. Since the last review, an area in which progress had been made was in the development and implementation of skills-based, and ability- or experience-based competency-based assessment for staff in a variety of areas. Such areas included behavior, healthcare, and physical and nutritional supports. Some work was needed to ensure necessary annual refresher training was defined for some of the clinical areas. However, overall, the progress in this area was notable, and appeared to have had a positive impact on the supports individuals at BSDC received.
A7	The State shall adequately supervise and monitor staff and residents at all times to ensure that staff are continually working to address resident needs.	*It is important to note that this is an extremely broad requirement that is difficult to measure objectively, particularly given the limitations of the monitoring visits (i.e., onsite for short durations). Within those limitations, the following summarizes the current status:* *<u>Areas in which Less Oversight is Necessary</u>* ▪ *Based on the structure and supervisory resources available at the Facility, adequate numbers of supervisors appeared to be available, and they had been assigned appropriately to be available on all shifts. This included direct line supervisors onsite, as well as an on-call system to ensure administrative oversight 24 hours a day, seven days per week. More specifically, at the time of the January 2012 review, three ICF/ID Administrators and the Deputy CEO, Administrator for Direct Services, were overseeing the five ICFs/ID. Shift Supervisors were assigned to each shift. It was anticipated that shortly after the onsite review, with the addition of one additional Shift Supervisor, the positions would be filled. The number of Shift Supervisors on duty during each shift varied from area to area, but was between two to four supervisors per area per shift. They did not have direct support duties, freeing them to take on other responsibilities. They were not assigned to a particular home, but were available across the ICF/DD to address staffing issues, injuries, training*

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		needs, disciplinary action, etc. Each ICF/ID had its own on-call rotation, resulting in the staff responsible for taking such calls being more knowledgeable about the individuals served within that particular ICF/ID. *Areas Requiring Focused Effort* ▪ *The State has added Health Coordinators and Behavior Support Specialists to the staffing of each ICF/ID at BSDC. It is anticipated they will play more of an oversight role, and provide training. A nurse also has been added to the Physical Nutritional Consultation Services (PNCS) Team. This should help with making sure plans are implemented.* Each of the ICFs/ID had Health Care Coordinators and Behavior Support Specialists. Based on discussion with staff about the roles of the staff in these positions, they appeared to be positive additions to the staffing structure. As noted with regard to Sections C and D of the Settlement Agreement, the addition of these positions appeared to positively impact the provision of behavioral and healthcare supports to individuals BSDC served.
A8	The State shall conduct a regular review of all resident injuries and "significant" incidents to determine if staffing concerns are a contributing factor; wherever this is the case, the State shall develop and implement prompt and effective measures to address the staffing concerns in order to provide adequate and sufficient staff to care for and supervise residents and to prevent otherwise avoidable injuries and incidents. "Significant" resident incidents include all instances of: alleged, suspected, and/or substantiated abuse and/or neglect; serious injury, including those of unknown origin; actual or attempted elopement from the facility; and death.	*Areas in which Less Oversight is Necessary* ▪ *In various forums, such as during the daily Incident Review Teams (IRTs) and in investigation reports, staffing issues were being discussed and identified on an incident-by-incident basis. These reviews identified issues such as those related to staff training, staff's understanding of their responsibilities when they signed individuals' programs, communication issues between staff, processes for handing off responsibilities for specific individuals to other staff, etc.* *Areas Requiring Focused Effort* ▪ *Work was needed to aggregate and analyze information related to staffing issues, and use it to make improvements on a systemic, as well as individual basis. This should occur at the Individual Review Team level, as well as on a Facility level, and should include various disciplines/departments, such as ICF/ID management staff, Human Resources staff, staff responsible for training, investigators, etc. The focus should be on analysis of incident reports and investigation results. It will be important to focus on pulling together information gained from these processes, and analyzing the information on an aggregate basis to determine if changes are needed.* As noted in the Independent Expert's last report, it appeared that in addition to the increased activities related to analysis of staffing issues that potentially were impacting allegations and other incidents, attention had been paid to developing and implementing action plans, or providing justification to not do so. The QI Quarterly Reports documented these decisions. This was an area in which the Independent Expert Team indicated less oversight was necessary moving forward, and so it was not assessed during this review.

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A9	Before permitting any staff person to work with residents, the State shall investigate the criminal history and other relevant background factors regarding that staff person, whether fulltime, part-time, temporary, or permanent, including regularly-scheduled volunteer staff with direct resident contact. The State shall screen and take appropriate action to protect residents if the investigation indicates that the person would pose a risk of harm to the residents.	*Areas in which Less Oversight is Necessary* ▪ *The BSDC Background Check Policy, dated 1/5/10, required the completion of a comprehensive set of background checks for new staff and volunteers, and when current staff changed positions. With the structural changes that had occurred through which staff had been assigned to the five ICFs/ID, the State survey agency required that all of the staff be treated as "new hires," requiring each to go through the full background check process. At the time of the most recent review, background checks had been completed for all staff assigned to the ICFs/DD.* ▪ *If convictions were identified, a review would be conducted to ensure that the applicant had disclosed the conviction. If so, an exception could be sought for some offenses. For an exception to be approved, the applicant would be asked for an explanation of the conviction. HR staff completed a summary of the offense and the staff member's explanation. This summary was forwarded to the Area Administrator, then the Deputy CEO Administrator for Direct Services, the CEO, the HR Director in Lincoln, and, finally, the Director of the Developmental Disabilities Division. All of these staff needed to provide approval for the staff to be hired or retained. Based on record reviews, it appeared that this was a thoughtful process that was designed to ensure that the individuals BSDC served were protected.* ▪ *On an ongoing basis, staff were required to report any law enforcement contact to their supervisor. The supervisor was required to report such contact to the HR Department. Decisions were then made with regard to whether the staff member could continue working or needed to be suspended until a decision was made regarding its impact on employment.* ▪ *Beginning in October 2011, the Facility initiated annual background checks for staff, which included a reasonable subset of the full set of checks that were completed at the time of hire.*
Resident Incidents		
A10	The State shall take effective steps to minimize incidents that may adversely impact the health, safety, and welfare of residents. This includes all "significant" resident incidents, especially those incidents that result in serious injury to residents.	*Section A10 requires implementation of the steps that are outlined in Section A11 through A13. As a result, the only item addressed in this Section is the adequacy of the BSDC's policy with regard to incidents, including "significant" incidents.* *Areas in which Less Oversight is Necessary* ▪ *In addition to the Abuse/Neglect policy, two BSDC policies addressed incident management, including Incident Management Policy #2.7, effective 8/27/11, and Incident Review Teams, #2.8, effective 11/15/10. Generally, these policies set forth reasonable mechanisms for reporting and following up on incidents that had the potential to adversely impact the health, safety, and welfare of individuals.* For informational purposes, the Monitoring Team shares the following data the Facility provided with regard to the numbers of serious reportable and reportable incidents. It is important to note that without further analysis, conclusions should not be drawn from the raw data only:

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Incident Category	1/1/12 through 12/31/12	1/1/13 through 12/31/13	1/1/14 through 1/31/14	2/1/14 through 2/28/14	3/1/14 through 3/7/14
Reportable Incidents:					
Airway Obstruction	Not reported	12	2	2	0
Absent without leave (AWOL)/Missing Person	0	0	0	0	0
Fall (with reportable injury)	7	25	0	3	0
Fall (without reportable injury)	365	363	34	27	5
Hospital/7911	Not reported	N/A	0	0	1
Ingestion of foreign material	17 (formerly "harmful substance")	23	1	1	0
Injury (needing beyond routine first aid)	52	50	6	5	2
Restraint related injury	4	N/A	0	0	0
Physical Nutritional Management incident	30	N/A	0	0	0
Suicide Ideation	Not reported	0	0	1	0
Total Reportable Events	475	473	43	39	8
Serious Reportable:					
Employee Abuse/Neglect Allegations by Incident	59 – unsubstantiated 13 - substantiated	69	7	4	0
Peer-to-peer Abuse Allegations Incidents (by Victim)	21– unsubstantiated 30 - substantiated	44	6	5	0
Death	2	1	0	0	0
AWOL/Missing Person	0 (formerly "elopement")	1	1	0	0
Fall with serious reportable injury	11	10	1	1	1
Hospitalization/Emergency Room (ER) visit	107	112	12	9	4

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		Ingestion of harmful substance (toxic/poisonous, sharp, significant threat of harm)	4	7	1	2	0
		Injury of unknown source	3	4	0	0	0
		Serious reportable incidents with injuries	11	16	2	1	1
		Law enforcement contact	21	4	0	0	0
		Physical Nutritional Management Incident	N/A	N/A	N/A	N/A	0
		Restraint-related injury (needing medical assessment or intervention)	0	2	0	0	0
		Spurious Assessment	Not reported	10	1	2	0
		Medication Error	Not reported	1	0	0	1
		Suicide or homicide incident (attempt to kill or harm self or others)	2	2	1	0	0
		Vehicle accident	11	5	0	2	0
		Total of Serious Reportable Events	295	288	32	26	7
A11	Whenever a significant incident (other than death) occurs, the State shall immediately take appropriate measures to protect the safety and well-being of the resident(s) involved, including procuring any necessary basic care and/or health care treatment.	*Areas in which Less Oversight is Necessary* ▪ *Policy:* ○ *The Incident Management Policy clearly indicated that staff members witnessing an incident/injury were to appropriately attend to the injury/incident to ensure the person was safe, including contacting nursing staff immediately to complete an assessment, if the individual sustained an injury. The Abuse and Neglect Policy, as well as the related training, emphasized the need for staff to intervene to stop the abuse or neglect, and protect the individual.* ○ *According to policy, staff were to report serious reportable incidents or allegations to shift supervisors and Administrators on Call (AOC). One of their roles was to ensure that appropriate immediate safeguards had been or were put in place.* *Areas Requiring Focused Effort* ▪ *Practice: The Facility, through its review of investigations, identified the same concern as the Monitoring Team regarding staff not consistently recognizing abuse or neglect, and intervening to ensure protection of the individual. Additional efforts to address this were necessary. Some of the*					

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		Monitoring Team's recommendations included: ○ *Enhancing training to provide direct support professionals with the skills to assertively intervene when a co-worker is engaged in an inappropriate workplace practice;* ○ *Expanding the use of competency-based checks; and* ○ *Incorporating regular discussions of abuse, neglect, and serious injury intervention and reporting as part of home or ICF/ID staff meetings, including actual scenarios.* As noted in the report for the review of BSDC the Independent Expert Team conducted in September 2012, the Facility had instituted some important interventions to ensure that staff were familiar with the requirements to not only report abuse and neglect, but also to first intervene to stop it and protect the individual. BSDC had continued and expanded its efforts to ensure staff were competent with regard to recognizing abuse and neglect, and intervening to ensure the protection of the individual through its ongoing training efforts. In addition, BSDC was using a quiz with direct support professionals. Based on a review of the quizzes and the resulting data, there was evidence to show that if staff needed retraining or feared retaliation, processes were in place to address these issues. An interview for individuals also was being implemented that should assist in making individuals more aware of what constitutes abuse and neglect, as well as to make sure they know they can bring concerns to staff. In a previous report, the Monitoring Team recommended that less oversight of this area was needed, and so additional review was not conducted during the most recent review.
A12	An interdisciplinary team on each BSDC living unit shall meet to identify, discuss, and address individual and systemic issues that have arisen since the last unit team meeting, as well as any individual and systemic issues that may arise before the next unit team meeting. The team's conclusions and action steps shall be conveyed across shifts to ensure continuity and consistency with regard to implementation efforts.	*Areas in which Less Oversight is Necessary* ▪ *For each ICF/ID on the BSDC campus, daily IRT meetings were being held to review incidents that had occurred the previous business day. The groups that met were interdisciplinary, and recommendations from the meetings were tracked.* ▪ *The goal was to ensure that the safeguards put in place in response to an incident were sufficient, and that safeguards the team had recommended in previous meetings had been taken.* ▪ *The IRTs were responsible for conducting more in-depth reviews of certain types of incidents, and reviewing investigation reports the Facility Investigators completed.* ▪ *Potential trends/issues related to individuals were discussed.* *Areas Requiring Focused Effort* ▪ *Potential trends/systemic issues across the ICFs/ID were not being identified/discussed or addressed. A methodology should be developed and implemented to ensure that the IRTs consider potential trends or patterns across individuals. The QI Department is responsible for pulling ICF/ID data on a monthly basis. This will be provided to the IRTs for review. In addition, a prompt will be added to the agenda to remind the teams to identify potential issues that affect more than one person. The intent should be to catch trends early, but not to complete a full trend report/review. If there appears to be a trend, then the ICF/ID Administrators can ask the QI Department to pull additional information. ICF/ID Administrators also meet regularly, and a*

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		prompt will be added to their agenda. ICF/ID Administrator/Clinical meetings also are held, and some of these issues are discussed. Based on a review of a sample of IRT meeting minutes for a week prior to the Independent Expert Team's onsite review, incidents had been reviewed, and the review teams had completed the prompts asking whether trends were identified. When the review teams identified trends for individuals (e.g., with regard to falls), the minutes reflected referrals to the IDTs for further review and follow-up. An example was provided in the minutes of the QI Team identifying the numbers of fractures across campus for the quarter. The minutes further stated that no trends had been identified with regard to the fractures, so the QI Team had not recommended follow-up. Reportedly, the QI Team also continued to meet with the ICF/ID Administrator group, and the group discussion any trends of concern. In summary, the Facility appeared to have continued its efforts to have both the ICF Administrator group in conjunction with the QI Team, as well as IRTs "identify, discuss, and address… systemic issues."
A13	On or before January 1, 2009, the State shall develop and implement across all settings and shifts an integrated and coordinated incident management system. All resident incidents, including incidents that result in injury, shall be accurately and consistently documented. Documentation of each injury shall be kept in the resident's file and in a central location, and all incidents and injuries shall be entered into a central database, which is capable of capturing the following information: the type of incident, the time the incident occurred, the location of the incident, the resident(s) and/or staff involved in the incident, and the nature and severity of the injury, if any. The State shall develop and implement, within 90 days, a policy mandating that staff report all incidents in a	*Areas in which Less Oversight is Necessary* ▪ *As noted with regard to Section A10, an adequate Incident Management policy was in place, describing reporting requirements as well as follow-up procedures.* ▪ *The Facility maintained a database that included information related to type of incident, date and time of incident, the individual(s) involved, and the nature and severity of the injury.* ▪ *The Facility had begun to look at whether incidents were preventable or not.* ▪ *As related to Section A12, individual incidents were reviewed through the IRT process and/or investigation process, and recommendations made as needed.* ▪ *The Quality Improvement (QI) Department tracked the recommendations.* *Areas Requiring Focused Effort* ▪ *At times, the QI Department requested confirmation or documentation to show that actions had been completed, and, at other times, the QI Department or Facility Investigators conducted onsite reviews to confirm completion of certain activities. However, action plans needed to identify the evidence required to confirm that an action item had been completed.* ▪ *In order for the Facility to utilize this data to effectuate an "integrated and coordinated incident management system," continued efforts were needed to conduct in-depth analysis of the data on an aggregate or cumulative level, resulting in the identification of recommendations for actions to be taken to address issues identified. The limited review occurring on the ICF/ID level in the Facility Quality Improvement Plan Executive Summaries required improvement. In addition, it also will be important for BSDC to look across the system to determine if trends exist, analyze those trends, and develop and implement plans to address potential underlying causes. With its January 2012 BSDC Overall Trend Report, it had just begun to implement this process.* ▪ *The QI Department's role in the review of incidents, and trending and analysis of information were*

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	timely manner.	*areas requiring further definition and implementation. As appropriate, the Senior Cabinet should consider and act upon recommendations emanating from the systemic reviews conducted.* As noted in the Independent Expert Team's last two reports related to BSDC, as evidenced in the QI Quarterly Reports, the Facility had begun to complete more in-depth reviews of incident and allegation data. Since the last review, this had continued. The QI Reports summarized results of the analysis of incidents, and investigation reports, with a focus on identifying root causes and determining the preventability of incidents. Since implementation of the Settlement Agreement began, improvements occurred with regard to BSDC's ability to identify and address such root causes. For example, in early 2012, some of the common themes that were identified as contributing factors to identified trends were staff not following individuals' BSPs, Safety Plans, or IPPs; staff being unclear about their roles; the need for improved interactions between staff and individuals; lack of communication between management, staff, and individuals; and staff being reactive as opposed to proactive. Since then, reports provided status reports on the action plans designed to address these issues, and noted if and why changes had been made to the original action plans. As noted in other sections of this report, the Facility had added positions to provide more opportunities for training and the provision of technical assistance to direct support professionals on BSPs and healthcare issues, which assisted in addressing some of the themes noted above. The implementation of some modules and ongoing expansion of Therap was another example of the Facility's efforts to reduce preventable incidents (such as medication omissions). Analysis of incidents and allegations was ongoing, and some new action plans had been initiated. Based on interview with members of the Compliance Team, a number of checks were in place when an incident occurred. The first step was ensuring safeguards were in place to protect the individual. Within the first 24 hours, the IRT as well as the QI Team reviewed the incident, and members of the QI Team attended IRT meetings a few days per week. The ICF Management Teams took responsibility for conducting the Preliminary Event Report, and determining the need for follow-up. When investigations were needed, the QI Team as well as IRT received a copy. At daily meetings, the QI Team reviewed incidents, investigations, as well as action plans developed, which the IRTs were responsible for approving, and also identified any trends. The QI Team and ICF Administrators discussed trends at weekly meetings, and IRTs also discussed trends the QI Team identified. Since the last review, a Compliance Specialist joined the QI Team, and was available to conduct more in-depth reviews of individual trends or systemic trends (e.g., an increase in falls and fractures resulted in a more in-depth review). Two nurses were now members of the QI Team, and assisted in review of health-related incidents and trends (e.g., medication errors). The action plans were all tracked to conclusion, and the QI Team conducted checks to ensure action plan steps were implemented, and outcomes were achieved. Overall, since the beginning of the implementation of the Settlement Agreement, improvement had

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		occurred with regard to the analysis of incidents and allegations. Given the various roads that analysis can take, Facility staff are encouraged to continue to ask the "why" question and expand analyses as necessary to identify root causes. In addition to systemic review of incident data on a quarterly basis, the QI Team had worked with the IRTs to increase the amount of relevant information available to conduct analyses. Facility staff also had worked to ensure that if analyses showed problems or trends related to incidents and allegations, action plans were developed to address them, or the rationale for either deferring action on them or not addressing them was included in the QI Quarterly Report.
Quality Assurance		
A14	The State shall develop and implement a comprehensive quality assurance program to track and analyze patterns and trends of incidents and injuries, including incidents and injuries of unknown origin. The State shall develop and implement prompt and effective measures to address patterns and trends that impact the health, safety, and welfare of residents, so as to minimize or eliminate their occurrence in the future.	*Note: Although this section of the Settlement Agreement addresses a quality assurance system related to incidents and injuries, a number of other sections require the implementation of quality assurance processes (e.g., Section C68 related to the development and implementation of behavior supports, D95 and D96 requiring a health care quality assurance program, D115 regarding nursing assessments and documentation, D127 related to the implementation of physical and nutritional management plans, and D136 requiring a quality assurance system for speech, occupational, and physical therapy supports). Given the overlap in the planning and types of processes that need to be developed and implemented for the comprehensive quality assurance system envisioned by these various section, the Monitoring Team has addressed the overarching components of such a system within this section.* *<u>Areas in which Less Oversight is Necessary</u>* ▪ *For purposes of the Settlement Agreement, the QI Department had adequate staffing, including a QA Coordinator, who supervised a Professional Development/Risk Management Coordinator; a Program Manager, in the role of Systems Compliance Analyst; a QI Staff Assistant, as well as five Home Leaders. The QDDP Coordinator also was part of the QI Department. The QI Department fell under the Deputy CEO, Administrator for Indirect Services.* ▪ *The Quality Improvement Policy #1.8, effective 8/27/11, set forth the parameters of the QI process. As reported previously, according to the policy, each ICF/ID and department was responsible for developing an annual QI Plan that incorporated the risk management goals and personal outcomes to meet BSDC's purpose of "Increasing Independence and Enhancing the Quality of Life for the Individuals Served." Each facility and department was responsible to routinely assess performance on its QI plan. The summarized reports would be submitted to the QI Department according to a predetermined schedule. The QI Department would conduct further review and analysis, and trends or patterns identified would be submitted back to the Area Administrator with recommendations for action. The QI Committee would review plans of action developed to address issues identified, and submit them to the Senior Cabinet for review and approval. Once approved, the plans would be implemented, and results monitored. The policy indicated that a "dashboard" of indicators would be developed for each facility, or ICF/ID. According to the policy, the QI Committee was responsible for analyzing "the aggregate data to provide an overview of the QI process for the campus." The QI Committee would submit the resulting overall report to the*

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		Governing Body, which had responsibility for monitoring the quality of the organization as a whole. Generally, except for a few issues that were easily addressable, the policy described an adequate comprehensive quality assurance program. ▪ *An appropriately constituted interdisciplinary QI Committee had been established.* *<u>Areas Requiring Focused Effort</u>* ▪ *The Facility had developed a Quality Plan. It set forth the processes the Facility intended to use for its quality improvement activities, which appeared appropriate. The plan provided a structure to assist in defining the indicators to allow the Facility to measure quality in various "quality domains." These included appropriate areas, such as dignity, health and wellness, integration and inclusion, safety, rights, etc. The plan also provided a format for identifying the data to be collected, the method for collection, the formula for calculating the results (i.e., often the numerator and denominator to calculate the percentage), the benchmark against which success would be measured, the baseline rate, and the target rate. For many indicators, the group had begun to define these components of the measurement system. However, this process was still in the development phase. Recognizing it would take time to finalize, BSDC staff anticipated that it would be finalized and full implementation would occur in July 2012. The Monitoring Team's reports included a number of recommendations related to ensuring the data generated is usable, valid, and reliable.* ▪ *BSDC staff also were working on simple formats for entering data, aggregating data to address key indicators, and allowing data to be reviewed easily on a number of different levels (e.g., individual basis, by program, or in total). These tools are necessary to provide staff at the Department-level a mechanism to collect the overall data needed, but also to trend the data, and analyze the data across a number of different variables, including the generation of graphs.* ▪ *In addition to dashboard indicators, the QA Department will need to develop different report formats for different audiences.* ▪ *Inter-rater reliability as well as the validity of monitoring results needed to be established. The Monitoring Team has offered recommendations, such as developing instructions, clearly defining methodologies and standards auditors will use, training auditors, using subject-matter experts, etc.* ▪ *The "BSDC Overall Trends/Patterns: 4th Quarter 2011 Facility Quality Improvement Plan," dated 1/30/12, was a helpful document that addressed positive outcomes as well as issues on a systemic level, and described the plans that had been developed to address issues identified. Continuation and expansion of this report was necessary as part of the implementation of a "comprehensive quality assurance program."* ▪ *Action plans required improvement. For the BSDC Overall Trends report, authors of the action plans needed to break down some of the larger tasks into more measurable and discrete tasks, and assign specific people responsible. In addition, improved analyses of the potential causes for problems were necessary to better inform many of the action plans included in the ICF/ID quarterly reports. Measurable outcomes also were needed, so that the success of the plans could be*

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		evaluated. ▪ *Follow-up on the actions plans also often was missing, and needed to be included to ensure that the intended outcomes were achieved, and, if not, the action plans were modified, as appropriate.* Over time, the BSDC quality improvement (QI) system had improved. As with any QI system, staff continued to work to refine the measurements, identify standards and benchmarks against which to compare BSDC's performance, and improve analyses of data. Previous reports describe many of the improvements made to BSDC's quality improvement efforts. The following summarizes past and more recent improvements as well as areas in which the Facility continued to make needed changes: ▪ As noted in the previous report, involvement of various staff in the quality improvement processes had expanded. This was evidenced in a number of ways. For example, based on review of the QI Indicator Dictionary and the Quarterly QI Reports, a number of staff from various disciplines were involved in the development and revision of indicators, as well as in the analysis of data. The Medical Department maintained some of its own indicators, but many had been incorporated into the Facility's overall QI efforts. The QI Team held regularly scheduled meetings with a number of departments, including the ICF Administrators to discuss results and develop action plans, as needed. ▪ As noted in the last couple of reports, the QI Indicator Dictionary generally set forth a set of basic indicators that should help the Facility to identify some of the areas in which the protections, supports, and services it provides are successful, and areas in which problems exist or more work is needed. They were divided into sections that addressed the safety of individuals, their health, efforts to assist individuals to become more independent, dignity and respect for individuals, staff's adherence to policies and procedures, supports and respect for staff, and whether BSDC was the employer of choice in the area. As discussed in previous reports, a natural part of the QI process is the need to modify the indicators based on experience and decisions about the usefulness of the data, as well as to focus on different aspects of treatment and supports. The Executive Summary for the 4th Quarter 2013 Quality Improvement Report explained the changes being made, including the addition, retirement, and modification of indicators. Given the number and type of supports BSDC provides, the opportunity to measure outcomes and processes is almost limitless. However, as previously discussed, it is essential that the Facility identify a reasonable number of measures for data collection and analysis to ensure that resources are available to conduct in-depth analysis to identify underlying causes of any problematic trends, as needed. BSDC is encouraged to continue adding to and subtracting from the indicators so that they continue to produce meaningful information and change. ▪ BSDC issued quarterly reports on QI indicators, which included analyses, and recommendations. Executive Summaries also were completed to offer a higher-level overview of the findings of the quarterly reviews. As noted in the Independent Expert's last report, the analyses in the quarterly reports continued to vary in depth and quality, although improvement in analyses continued to be evident. For example, on a positive note, now that more historical data were

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		available, analysis was done across longer periods of time (e.g., a year or more). Clearly, staff were working hard to conduct detailed analyses, but it will continue to be important to search for the root causes of trends identified. ▪ As noted in previous reports, the Facility was utilizing a number of monitoring tools for which inter-rater reliability as well as the validity of monitoring results needed to be established. After reviewing comments from the State after the last draft report, the Independent Expert asked the parties to resolve the question of whether these were requirements of the Settlement Agreement. The parties did not respond, and, as a result, the Independent Expert did not assess the Facility's efforts in this regard for this review. On a positive note, though, Facility staff reported that they had begun to talk about ways in which inter-rater reliability could be established for processes such as the Home Leader audits. The Independent Expert Team continues to encourage the Facility to engage in such efforts, given the importance of having both valid and reliable measures in place as the basis for a QI system. The Independent Expert Team's previous reports have outlined some of the steps that could be taken to assist in this regard, and identified some of the steps the Facility had taken (e.g., an inter-rater reliability process had been defined, and helpful instructions had been developed for the IDT meeting process, the IPP draft/final checklist, and the quarterly meeting checklist). ▪ The Quarterly QI Reports summarized action plans implemented to address trends, and provided a historical perspective of action plans implemented and their status. To reduce the length of the reports, some of this information could be summarized or archived. However, it is important to maintain a record of action plans implemented and their impact on the problems identified. As the reports showed, a number of the action plans implemented resulted in improvements in both processes and outcomes for individuals. In summary, as noted in the last report, the Facility had demonstrated the ability to develop indicators addressing many aspects of the quality of the protections, supports, and services it offered individuals, including some outcomes related to their health, wellbeing, and independence. As BSDC had done over the last couple of years, these indicators should continue to be reviewed and revised with focus on the identification of valid measures, using measurement techniques that result in the collection of reliable data. As goals are achieved with the measures identified, the Facility should identify new measures to address other important aspects of the quality of protections, supports, and services. In its quality improvement efforts, BSDC was using a combination of monitoring/auditing and review of other data sources. Analysis of data had continued, and now with more historical data available, comparisons were being made across time. In-depth analysis with attention to the identification of root causes should continue to be a focus moving forward. At this juncture, the Facility had a variety of report formats that addressed the needs of various audiences. The reports summarized action plans implemented, and in a number of cases, data showed that the plans implemented had resulted in improvements for individuals. Although as the Facility recognized, its quality improvement system was an ongoing work in progress, in terms of the requirements of the Settlement Agreement, BSDC had developed the basic QI structure

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		needed to identify problematic trends in a number of areas, conduct analysis, take action to address suspected causes, and evaluate whether the actions were effective.
A15	The State shall place an emphasis on identifying and analyzing resident-to-resident interactions that create risk of harm and/or actual harm, and then develop and implement measures to address these risk factors to prevent residents from harming themselves or others. The State shall identify vulnerable residents who are at higher risk of harm, and develop and implement measures to minimize or eliminate potential risk factors. The State shall identify aggressor residents and develop and implement measures, in conjunction with behavioral and other interventions, to minimize or eliminate potential triggers for aggression.	*Areas Requiring Focused Effort* ▪ *Action plans generally remained inadequate in relation to peer-to-peer aggression. Often, they showed inadequate analysis of the potential underlying issues, and did not include specific action steps. For example, it did not appear that information gained from the investigation processes was integrated into the review and analysis of data, and/or the development of action plans to address the underlying issues.* ▪ *Improvement also was needed with regard to determining whether or not the action plans had been implemented as written, and if the outcomes had not been achieved, then modifying the plans.* ▪ *The severity of the aggression needed to be analyzed. Although peer-to-peer aggression is serious whenever it occurs, reviewing the severity (e.g., injuries incurred, level of intimidation, etc.) was necessary to help in prioritizing individuals who should not live together, require external behavioral consultation, etc.* ▪ *A pilot program incorporates a piece regarding looking at peer-to-peer issues. This is being expanded. Also, the Behavior Specialists will be involved in the process.* As noted in the Independent Expert's last report, BSDC made and sustained its progress in this area. By involving the QI Team in the analysis of the peer-to-peer abuse data, as well as the investigation reports completed for each incident, more in-depth information was available with which to make decisions about next steps. Decreasing trends also were noted with regard to numbers of incidents, numbers of victims, as well as numbers of individuals that were the aggressors. The QI Committee also was looking at the severity of injuries resulting from these incidents, which was important. As a result, the Independent Expert Team recommended this be an area requiring less oversight. A full review was not conducted this time, but it is worthy of note that the Facility's data continued to show decreasing trends with regard to peer-to-peer incidents of aggression. According to the 4Q13 Quality Improvement Report Executive Summary, dated 3/26/14, "With regard to Peer-to-Peer Incidents of Aggression, the target of 0% was not met for this quarter, but the results for this quarter (1.5%) and the 2013 average (2.53%) were both significantly bellow the baseline of 15% (from 3Q11). Significant efforts have been undertaken to reduce incidents of aggression between individuals supported by BSDC, and clear progress has been made. Efforts have included staff training, improved Behavioral Support Plans (BSPs) and implementation for individuals, and thorough review/root cause analysis when incidents occurred." The Independent Expert Team commends Facility staff for their commitment to and active pursuit of reducing risk in relation to peer-to-peer incidents of aggression. These efforts clearly have resulted in improved quality of life for individuals the Facility serves.

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Investigation of Significant Incidents		
A16	The State shall investigate all "significant" resident incidents. As referenced above, "significant" resident incidents include all instances of: alleged, suspected, and/or substantiated abuse and/or neglect; serious injury, including those of unknown origin; actual or attempted elopement from the facility; and death.	*Areas in which Less Oversight is Necessary* ▪ *The Abuse/Neglect Policy #2.2, effective date 1/31/12, outlined the process for investigation of abuse and neglect allegations, and deaths. The Incident Management Policy #2.2, effective date 8/27/11, included a statement that QDDPs would investigate Serious Reportable Incidents. In practice, the Facility's Investigators were investigating a number of serious reportable incidents, including peer-to-peer incidents, and serious injuries, such as fractures.* ▪ *Tracking mechanisms were in place through either the IRT for serious reportable incidents or the investigations unit to ensure completion of investigation reports.*
A17	The investigation of each significant incident shall be accurate, thorough, and complete. Investigations are to commence at least by the next working day of the incident being reported, and shall be concluded within 30 days of the incident being reported, or, when material evidence is unavailable to the investigator, as soon as is practicable so as to eliminate any undue delay. Other than with regard to matters involving a criminal investigation conducted by law enforcement authorities, investigators shall conduct interviews of all necessary witnesses in a timely manner. Each investigation will result in a written report. Each investigation report shall include: a summary of the incident and investigation, a chronology of events, a summary of interviews with all relevant staff and residents who may have information about the incident, findings with a detailed discussion of the bases for the findings	*Areas in which Less Oversight is Necessary* ▪ *Based on the January 2012 review, generally, the following requirements were being met:* ○ *Investigations commencing at least by the next working day of the incident being reported;* ○ *Investigations being concluded within 30 days of the incident being reported;* ○ *Appropriate deferment to law enforcement so as to not compromise criminal investigations;* ○ *Investigation reports including: 1) a summary of the incident and investigation; 2) chronology of events; and 3) a summary of interview statements; and* ○ *Investigators had been provided with competency-based training on the investigations process and all investigators had relevant experience.* *Areas Requiring Focused Effort* ▪ *With regard to investigations and the resulting reports, concerns continued to be noted in relation to: 1) the completion of adequate and appropriate interviews; and 2) adequate bases for the findings and/or reconciliation of the evidence.* ▪ *A related issue was whether or not the potential list of "findings" was adequate, and the Monitoring Team recommended consideration of an additional category of "inconclusive."* *Note: The requirement in this section related to recommendations is addressed with regard to Section A18.* As noted in previous reports that addressed BSDC, the Facility had appropriately added and begun to use an "inconclusive category." Progress also was seen with regard to the completion of adequate interviews of relevant witnesses for investigations. The area requiring continued focused efforts was ensuring evidence reviewed for investigations is adequate and the investigation reports document adequate reconciliations of the evidence to provide adequate bases for the conclusions. As a result, that was the area of focus of this review.

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	(including a reasoned analysis of witness statements, documents, and other evidence considered), and recommendations for corrective action, when necessary, with timeframes for completion. The State shall ensure that investigators are competent, experienced, and well-trained in conducting investigations of significant incidents.	As noted in the documents reviewed section, the Monitoring Team reviewed 10 investigations that the Division of Developmental Disabilities investigators had conducted in relation to allegations of abuse and neglect at BSDC. These included: AN-14-004, AN-14-010, AN-14-016, AN-14-019, AN-14-023, AN-14-026, AN-14-031, AN-14-032, AN-14-034, and AN-14-035. These represented some of the most recent investigations at the time of the Independent Expert Team's review, as well as a sample across investigators and ICFs/ID at BSDC. Investigators reported to the DDD Quality Improvement, Certification, and Contract Compliance Manager. The Manager had reviewed all of the investigations in the sample. In addition ICF Administrators had reviewed all of the sample investigation reports and agreed with the findings. Based on a review of the sample of investigation reports, in general, the investigations showed thorough reviews, including a review of documentary evidence, as well as staff interviews, and physical evidence, as appropriate. All 10 investigations also provided of an adequate basis for the findings and/or reconciliation of the evidence. This was an area that showed improvement over time. At this juncture, the Independent Expert Team recommends that the parties consider this an area requiring less oversight.
A18	The State shall develop and implement prompt and effective remedial measures to address the individual and systemic issues and recommendations associated with these investigation reports. The State shall track the implementation of the remedial measures on an ongoing basis to ensure that outstanding issues are addressed and appropriate resident outcomes are achieved in each instance.	*Areas Requiring Focused Effort* ▪ *Although improvements were seen in recent reports, focus was still needed to ensure adequate, thorough recommendations were included in investigation reports.* ▪ *The resulting action plans also needed to be thorough and measurable. BSDC needed to improve the measurability of the action steps, as well as identify the evidence the person responsible would need to present to demonstrate completion of the action step, and/or the improved outcome expected. As appropriate, when physical confirmation of completion of an action step is needed (e.g., interviews with staff, confirmation that a change has been made to the environment, etc.), this should be noted, and a person assigned (e.g., supervisory staff, quality improvement staff, etc.) to follow-up.* ▪ *Although a tracking system was in place, follow-up appeared stymied because of the lack of measurable objectives/outcomes, inadequate measures, and missing timeframes for completion.* ▪ *As noted with regard to Section A13, systemic issues were not routinely being identified, recommendations made, and remedial actions developed, implemented, and monitored.* At the time of the last review, based on the improvements seen in this area, the Independent Expert Team recommended that this be an area requiring less oversight. As a result, a review was not completed for this report.
A19	The State shall require staff, including supervisory personnel, to	*Areas in which Less Oversight is Necessary* ▪ *Generally, the Facility had adequate procedures in place, and Facility policy included adequate*

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	safeguard evidence associated with the significant incident.	*requirements for safeguarding evidence. An evidence room was available that was double-locked. Review of investigation reports showed that the majority of the evidence was documentary, including documents, as well as photographs and drawings used to provide better contexts to staff's statements. Generally, as appropriate, measurements were noted, and pictures were taken to preserve evidence. Occasionally, physical evidence was secured and the chain of custody maintained.*
A20	The State shall require that all potential criminal matters are referred promptly to appropriate law enforcement authorities. When law enforcement authorities indicate an intent to proceed with a criminal investigation, any compelled interviews of State employees shall be delayed until those authorities issue a written declination to proceed with a criminal investigation.	*Areas in which Less Oversight is Necessary* ▪ *Based on staff interview, BSDC was sending notifications of investigations to the Gage County Attorney and the State Patrol. However, often no response was received. If an allegation appeared to be one that a criminal case likely would be considered/opened, BSDC staff were proactively contacting their contact at the State Police to discuss how to proceed. Based on review of investigation reports over the last year, some examples were seen of clear collaboration with law enforcement, including delaying interviews of State employees until law enforcement provided clearance.*
A21	The State shall immediately remove any staff member suspected of staff-on-resident abuse or neglect from direct resident contact until the conclusion of the investigation and submission of the written investigation report about the incident.	*Areas in which Less Oversight is Necessary* ▪ *Facility policy clearly required alleged perpetrators to be removed from direct resident contact.* ▪ *Based on review of investigations and other documentation, this was occurring pending the completion of the investigations.* ▪ *When investigation reports substantiated abuse, neglect, or exploitation, or other issues were identified, the recommendation sections of the Reports of Investigation recommended the Area Administrator follow-up with the HR Department for cases requiring disciplinary action. When allegations were not substantiated and other issues were not identified, the recommendation was made to return the staff person to work.*
A22	The State shall impose appropriate disciplinary and/or corrective personnel action where a staff person is determined to have caused or been responsible for abuse and/or neglect, and against any staff person who fails to report a significant incident to supervisory or other appropriate personnel in a timely or accurate	*Areas in which Less Oversight is Necessary* ▪ *As noted in a number of reports, it appeared that BSDC management staff had made reasonable decisions with regard to the type and level of disciplinary action taken based on the facts of the cases related to abuse, neglect, and exploitation allegations. The letters that were addressed to the staff who had been responsible for the abuse or neglect clearly articulated the Facility's "zero tolerance" for abuse and neglect, as well as for retaliation against anyone involved in the allegations or investigations.* ▪ *Examples also were seen of appropriate disciplinary action, up to and including termination, taken in cases in which staff failed to report abuse, neglect, and/or exploitation.*

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	manner.	

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

SECTION B: Placement in the Most Integrated Setting

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - Organizational Chart for Department of Health and Human Services (DHHS), Division of Developmental Disabilities (DDD), revised 3/21/14;
  - Organizational chart for the Division of Children and Family Services, Adult Protective Services Division, undated;
  - Master DOJ BSDC Census and Transition Data, updated 3/14/14;
  - Community Coordination Specialists' (CCS) Caseloads, dated 3/14/14;
  - Developmental Disabilities Service Coordination (DDSC) Individual/family meeting – Personal Focus Worksheet, dated 4/2014;
  - DDD Sower Newsletter;
  - DDD State Plan Forums 2013-2014 packet;
  - Functional Behavior Assessment training packet;
  - 2013 Annual Report from contractor for Intensive Treatment Mobility Services (ITMS) (formerly Team Behavioral Consultation);
  - ITMS Logic Model;
  - ITMS Focus Group Results – Service Coordinators;
  - Summary of training sessions provided and anticipated (2014) by ITMS provider;
  - Training packets:
    - Self-care and Boundaries…;
    - Serving Individuals with Co-Occurring…; and
    - Conducting Serious Incident Investigations;
  - ITMS Provider Marketing Materials for Future Trainings in 2014;
  - Records review for the following individuals: Individual #419, Individual #415, Individual #77, Individual #417, Individual #132, Individual #232, Individual #400, Individual #286, and Individual #341;
  - Records for the following eight individuals: Individual #33, Individual #109, Individual #344, Individual #254, Individual #200, Individual #169, Individual # 285, and Individual #111, including, as provided: most recent Individual Program Plan; assessments; Intake and Planning meeting documentation; 30-day IPP; Transition Plans; documentation of visits to future home, and staff visits to BSDC and future home; CCS monitoring documentation, including previous monitoring form and revised monitoring form, and case notes; documentation of physician contacts, orders, and recommendations; routine and specialty medical care appointment documentation; behavioral and/or psychiatric care appointments notes and data; nursing care plans; therapy notes and assessments, including Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), and Wheelchair assessment; Physical Nutritional Support (PNS) plans, mealtime plans, therapy programs, and others, as available; incident reports; hospitalization documentation; daily activity schedules, staff logs, and data; risk assessments; nutritional assessments and documentation; functional assessments (FAs); staff training documentation; documentation of protocols for care; "flow sheet" information [e.g., weights, bowel movements (BMs), seizures, range of motion (ROM), etc.]; specialty meeting minutes for meetings held outside of the IPP to address any risk events; and human rights documentation.
  - For individuals in the sample, DDD Nurse Specialist reports, as available;
  - Spreadsheet showing follow-up to recommendations from the DDD Nurse Specialist reviews;
  - Spreadsheet showing individuals' scores for risk ratings across the three screening tools;
  - 2013 Summary Information pertaining to Deaths of Individuals Receiving Developmental Disabilities Community-Based Services;
  - Minutes from provider meeting at which mortality information was discussed;
  - Agenda for "It's My Life" conference;

- Form/template that DDD nurses use to complete their annual review of individuals nursing/medical supports, including any instructions/guidelines;
- Resource manual that the Nurse Specialist developed to share with community nurses;
- Complaint DDD filed related to Individual #33 regarding concerns at nursing home;
- Community Coordinator Specialist monitoring form(s) template with any related instructions;
- Records for the following 10 individuals: Individual #109, Individual #344, Individual #111, Individual #285, Individual #169, Individual #200, Individual #33, Individual #254, Individual #143, and Individual #65, including: the most recent Individual Program Plan developed for the individual; monitoring tools completed by the CCS for the last six-month period; notes or other documentation of any follow-up completed to address any concerns identified through the CCS monitoring process; in-service training, including agenda and handouts for the past year for any training related to the therapies (OT, PT and SLP), dietary/nutrition, as well as physical and nutritional supports; OT/PT/SLP schedule in the home and off-site, if applicable; OT/PT/SLP assessments; OT/PT/SLP consultations for the past year; OT/PT/SLP programs and monthly progress notes for the past year; dining/mealtime plans, including diet texture and fluid consistency; oral hygiene/tooth brushing plans; bathing/showering plan; medication administration plan; personal care plan; wheelchair and alternate positioning plans; transfer plans; dental evaluation for past year; annual nutrition assessments and quarterly updates; current physician orders for diet texture and fluid consistency; weight history by month for past year; competency-based staff training documentation for individual-specific plans (i.e., mealtime, tooth brushing, bathing/showering, wheelchair, alternate positioning, transfers, personal care, medication administration); individual-specific monitoring for plans; pleasure/therapeutic feeding program, if applicable; BSDC PNCS assessment and recommendations, if applicable; community PNS assessment and recommendations, if applicable; BSDC Spine and Gait Clinic assessment and recommendations, if applicable; Modified Barium Swallow study; Video fluoroscopy or any swallowing study (i.e. Bedside Swallowing study) within the last year; current PNM 40 Question Risk Assessment; Spine and Gait Risk Assessment and Medical Risk Assessment and rating results completed by Community Coordination Specialist and/or community providers; status of Community Recommendations from Medical Review Team; and daily schedule;
- Community Medical Team Visits, Recommendations, and Follow-Up;
- Individual #77: she was seen in her residence, and various clinical staff were interviewed; also reviewed: provider agency form from psychiatric contact of 9/24/13; IPP of 3/4/14; laboratory test results of 10/1/13; provider agency's form from annual history and physical (H and P) of 9/25/13; Behavioral Support Plan of 9/25/13; and consultation note from BSDC psychiatrist (consultation of 5/6/13; note recreated by consultant 5/1/14);
- Individual #132: she was seen in her residence, and various clinical staff were interviewed; also reviewed: IPP of 12/5/13; and formal psychiatric notes of 7/19/13, 10/4/13, 11/15/13, and 2/7/14;
- Individual #232: he was seen in his residence, and various clinical staff were interviewed; also reviewed: IPP of 3/6/14; and transition plan of 5/1/13;
- Individual #286: he was seen in his day program, and various clinical staff were interviewed; also reviewed: IPP of 10/24/13; provider team forms to PCP and psychopharmacologist, from 1/2/13 to 2/20/14; results of laboratory tests, from 1/31/13 to 2/20/14; side effect monitoring forms from provider agency, and September 2013 to February 2014;
- Individual #341: he was seen in his day program, and various clinical staff were interviewed; also reviewed: provider agency forms from psychiatric contacts of 1/23/13, 5/22/13, and 3/6/14; IPP of 2/26/14; and note from contact with primary care physician, dated 1/30/13;
- Individual #400: she was seen in her day program, and various clinical staff were interviewed; also reviewed: cards for medications dispensed by program, April 2013 to March 2014; IPP of 12/5/13; Nursing Care Review Plan follow-up of 3/4/14; provider agency forms from psychiatric contacts, from 2/1/12 to 11/22/13; and Psychological Assessment of 12/12/11;
- Individual #415: he was seen in his residence, and various clinical staff were interviewed; also reviewed: IPP of 1/17/14; psychological

evaluation of 4/12/13; Nursing Care Review report of 12/6/13 with follow-up of 1/17/14; and consultation forms from psychopharmacologist to provider agency, from 12/26/12 to 12/13/13;
- Individual #417: she was seen in her residence, and various clinical staff were interviewed; also reviewed: IPP of 12/12/13; formal psychiatric notes from contacts of 9/14/10 through 12/5/13; provider agency form from psychiatric contact of 3/4/13; and Nursing Care Review Plan of 3/7/13 and follow-up;
- Individual #419: he was seen in his residence, and various clinical staff were interviewed; also reviewed: and IPP of 2/19/14; provider agency form from psychiatric contact of 2/3/14;
- Individual #411: medical notes for the three months prior to and subsequent to the cardiology consultation of 12/5/13; all laboratory studies in that period; the most recent H and P to the consultation; forms provided to the consultant prior to the consultation; and the consultant's report;
- Individual #94: medical notes for the three months prior to and subsequent to the podiatry consultations of 1/14/14 to 2/19/14; all laboratory studies in that period; the most recent H and P prior to the consultation; forms provided to the consultant prior to the consultation; and the consultant's report;
- Individual #48: medical notes for the three months prior to and subsequent to the consultation of the surgeon on 1/6/14 for follow-up of gall bladder removal; all laboratory studies in that period; the most recent H and P prior to the consultation; forms provided to the consultant prior to the consultation; and the consultant's report;
- Most recent IPPs of thirty individuals living in the community, followed by non-BSDC psychiatrists;
- Samples of IPPs using the new format that were completed for individuals the Settlement Agreement covers, including those for Individual #16, and Individual #49;
- Conference announcement for Success, Hopes, and Dreams 2014: Creating New Possibilities and Overcoming Challenges, held May 19 to 21, 2014;
- Number of individuals Settlement Agreement covers with continuous versus intermittent employment services;
- Adult Protective Services (APS) Investigation Summary CQI (Continuous Quality Improvement) Report, prepared on 3/13/14;
- APS Investigation Summary QI Case Review format, dated 12/16/13;
- Adult Protective Services, Chapter 4.A: Intake, updated 4/1/14;
- APS graphs showing timeliness of contact and investigation completion, and quality indicators for investigations, dated 3/20/14;
- List of APS online training resources;
- Agenda for APS Operations/CQI Meeting on 3/26/14;
- DD Surveyor Meeting Agenda/Minutes for October 2013 through March 2014;
- For private provider, numbers of individuals in three original work centers, and numbers of individuals now in two programs, with a breakdown of numbers competitively employed and number involved in community volunteer programs;
- Email from Jodi Fenner to community providers with subject line: February 2014 Issue of Federal Perspectives, dated 2/26/14;
- Complaint DDD filed regarding Individual #33;
- Complaint DDD filed regarding Individual #223;
- DDD involvement in advocating for action or removal of guardians;
- Summary of DDD efforts regarding nursing facilities;
- State's response to request for numbers of individuals the Settlement Agreement covers on polypharmacy presently and in 2009;
- For each ICF/ID, a sample person-centered individual plan that has been developed within the three months prior to the review, and all related assessments, including those for: Individual #268, Individual #55, Individual #109, Individual #192, and Individual #277;
- Guardian Opposition to Transition Report, March 2014;
- Current transition plans for the three individuals anticipated to move next to the community, as well as their current IPP, and related assessments, including those for: Individual #378, Individual #359, and Individual #164;

- Qualified Developmental Disabilities Professional (QDDP) Coordinator Status Update, revised;
- QDDP Support Services – Quality Improvement Team, dated 12/1/13;
- Fading Process for QDDP Document Review Guidelines, updated 3/31/14;
- Updated QDDP Checklists;
- IPP format with red hints
- Draft Monitoring of Community IPP Quality Assurance/Process Guidelines and packet;
- Article from local newspaper regarding Individual #400 and private provider's supports;
- For the last six months, training agendas and/or curriculum for CCSs, including a description of any competency-based assessments;
- Service Coordinator Monitoring Form and Instruction, dated 3/21/14;
- CCS Monitoring Form Addendum and Instructions, undated;
- For the last 15 critical incident reports submitted to DDD for individuals the Settlement Agreement covers, incident reports for the critical incidents, as well as any documentation of follow-up activity, including but not limited to specific follow-up the CCS took, investigations or survey activity initiated, etc.;
- For the last six-month period, the date on which any allegations of abuse and/or neglect were made for individuals the Settlement Agreement covers, the date the CCS was notified, and the status of the investigation;
- For the last 10 allegations of abuse, neglect, or exploitation for individuals the Settlement Agreement covers, and for which APS accepted the allegation for investigation, documentation of any APS investigation completed, including but not limited to investigation files; reports; summaries of investigation activities, such as, but not limited to, initiation of the investigation, efforts to secure evidence, lists of evidence reviewed (i.e., testimonial, physical, documentary, and demonstrative) and dates collected; copies of witness statements; copies of documentary and demonstrative evidence; documentation of interviews; the investigator's reconciliation of the evidence; conclusions of the investigation; and recommendations, including for: Intake #527838; Intake #518111; Intake #522597, Intake #523334, Intake #513586, Intake #525520, Intake #516571, Intake #510559, Intake #528769, and Intake #530098;
- For the 10 investigations referenced above,
  - Correspondence sent to private community providers and CCSs notifying them of the initiation of the investigation, as well as the results of the investigation, including any recommendations to ensure the implementation of adequate steps to address staffing and programmatic issues identified in the conduct of the investigations;
  - Corresponding community provider investigation reports;
  - Any correspondence between DDD and APS to coordinate the investigation, share the results, and/or appeal decisions made by APS; and
  - Documentation of follow-up activities by provider and/or Service Coordination staff;
- For the last 10 complaints for which DDD initiated a complaint review, a copy of the complaint, documentation of the investigation/inquiry into the complaint, source documents used in completing the complaint investigation, and any follow-up documentation, including but not limited to notes indicating follow-up action, survey/certification activity, plan(s) of correction from the provider agency, etc. Documentation was provided for: Complaint #245, Complaint #308, Complaint #271, Complaint #305, Complaint #278, Complaint #306, Complaint #247, Complaint #307, Complaint #299, and Complaint #303;
- For the last 10 allegations of abuse, neglect, and exploitation for individuals the Settlement Agreement covers that APS screened out as not meeting the definition, the documentation describing the allegation and the specific reasons for which they were screened out;
- Quality Improvement (QI) Committee meeting agendas and minutes, for meetings on 10/17/13, and 1/16/14;
- For each individual who has transitioned to the community since October 19, 2007, in alphabetical order by individual, a list for the last six months of each significant incident and/or allegation of abuse and neglect, including date of occurrence, date of report, name of provider(s), brief description of incident/allegation, and status;
- For each individual who has transitioned to the community since October 19, 2007, in alphabetical order by individual, a list for the

last six months of each complaint, including date complaint made, name of provider(s), brief description of complaint, entity responsible for the investigation of the complaint, status, and result;
- Analyses completed or action plans developed in response to the data related to incidents and/or complaints;
- General Event Report (GER) Review Process by Technical Assistance Consideration for Team Behavioral Consultation Referral;
- For individuals who have transitioned from BSDC since October 19, 2007, for the last one-year period, the total numbers for each of the following:
  - Deaths;
  - Abuse allegations, including a breakdown of those that were substantiated, unsubstantiated, and inconclusive;
  - Neglect, including a breakdown of those that were substantiated, unsubstantiated, and inconclusive;
  - Mistreatment, including a breakdown of those that were substantiated, unsubstantiated, and inconclusive; and
  - Each remaining serious incident category as defined by State policy/regulation;
- Considerations of Incidents Reported to the DDD Community Based Services;
- State of Nebraska DHHS – Divisions of Developmental Disabilities GER Instructions: Department approved format for written reports of incidents for Community Based Providers, effective 1/1/14;
- DDD 2013 Presentation and Training Log;
- DDD 2014 Presentation and Training Log;
- Information about Project Search Conference in July 2014;
- Letter regarding rate methodology implementation, dated 3/6/14;
- DDD Review of Provider's Internal Investigations, undated;
- Audit of Complaint Reviews/Documentation, undated;
- Audit of Investigations/Documentation, undated;
- Five survey and certification reports, related correspondence, and any resulting plans of correction;
- Most recent IPP, and related assessments, and transition plan, if completed in the prior six months, for the following: Individual #143, Individual #111, Individual #65, Individual #286, Individual #77, Individual #232, Individual #415, Individual #344, Individual #254, Individual #341, Individual #419, Individual #400, Individual #200, Individual #169, Individual #109, Individual #132, Individual #285, and Individual #417;
- Since the Monitoring Team's onsite review in May 2013, for any individuals that transitioned from BSDC or Bridges to the community, their transition plans, the related assessments, their most recent IPP, and BSP, if any, including those for Individual #232, and Individual #132; and
- Division of Developmental Disabilities Updates notebook, dated 12/31/13, addressing:
  - Community-Based Services;
  - BSDC;
  - Technical Assistance; and
  - Bridges.

- **Interviews with**:
  - Jodi Fenner, Director, Department of Health and Human Services Division of Developmental Disabilities (DDD);
  - Tricia Mason, Administrator, Community-Based Services, Division of Developmental Disabilities;
  - Kathie Lueke, Deputy Administrator of Quality Improvement (QI);
  - Angie Ludemann, DOJ Transition Manager;
  - Todd Stull, M.D., BSDC Medical Director;
  - Laura Allen, DDD Quality Improvement, Certification, and Contract Compliance Manager;

- Gwen Hurst-Anderson, Technical Assistance Manager for DDD;
- Nathan Busch, Division of Children and Family Services (DCFS), Unit Administrator, Child Protection and Permanency Unit;
- Julie Hippen, DCFS, Program Specialist;
- Darla Ramsey, DDD Nurse Consultant;
- Michelle Waller, DDD Nurse Consultant;
- Terri Lykins, PNCS Director, RD, LMNT;
- DHHS CCSs for the following individuals: Individual #419, Individual #415, Individual #77, Individual #417, Individual #132, Individual #232, Individual #400, Individual #286, Individual #341, Individual #33, Individual #109, Individual #344, Individual #254, Individual #200, Individual, #169, Individual #285, Individual #143, Individual #65, and Individual #111; and
- Community provider staff, including:
  - Direct Support Professionals (DSPs);
  - Medical and nursing staff;
  - Vocational and day program staff;
  - Behavioral services staff and consultants; and
  - Management/supervisory staff [e.g., Executive Directors, site directors, Qualified Developmental Disability Professionals (QDDPs), supervisors, etc.].

- **Observations of and Interviews with:**
  - The following individuals in their residences and/or day programs: Individual #419, Individual #415, Individual #77, Individual #417, Individual #132, Individual #232, Individual #400, Individual #286, Individual #341, Individual #33, Individual #109, Individual #344, Individual #254, Individual #200, Individual, #169, Individual #285, Individual #143, Individual #65, and Individual #111.

SECTION B: Placement in the Most Integrated Setting		
#	**Provision**	
Principal Requirement		
B23	In accordance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, and implementing regulation 28 C.F.R. § 35.130(d), the State shall ensure that each BSDC resident is served in the most integrated setting appropriate to meet each person's individualized needs. To this end, the State shall actively pursue the appropriate discharge of BSDC residents from BSDC and provide them with adequate and appropriate protections, supports, and services, consistent with each person's	*As the principal requirement, a number of the subsections of Section B are related to the implementation of this requirement:* ▪ *Due to its relationship with adequate monitoring, the Monitoring Team has continued to address the requirement embedded in Section B23 for the State to provide individuals "with adequate and appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object" in its assessment of Section B48.* ▪ *Other subsections of the Settlement Agreement that influence the State's ability to meet the requirements contained in Section B23 are B27, B28, and B31, which involve the need to document the individual's informed decision, and address family members'/guardians' concerns related to community transition. These are discussed below.* ▪ *In terms of the State's efforts to offer individuals with options in the "most integrated setting in which they can be reasonably accommodated," the capacity of the system is discussed with regard to Section B43 and B44.* *Areas in which Less Oversight is Necessary*

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	individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object.	*Funding was not identified as an issue that prevented individuals the Settlement Agreement covered who choose to move to the community to move. No waiting list existed for individuals living at BSDC/Bridges or former residents in nursing homes to move to the community.* *Areas Requiring Focused Effort* *Given that this is the overarching requirement for this section, the Independent Expert recommends continued monitoring and reporting of the following statistics:* On 10/19/07, the United States completed its initial review of BSDC. Since that time, 353 individuals resided at the Facility. As of 3/14/14, based on data the State provided, the status of those individuals was as follows: ▪ BSDC census – 126 individuals (36%). Seven individuals were in some phase of transition planning to move from BSDC to the community; ▪ Bridges program census – seven (2%), all of whom were now living in three four-person State-operated community homes; ▪ In community placement – 97 (27%), living in small community-based developmental disability settings, or with family; ▪ In Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) community placement – 22 (6%); ▪ In nursing facilities – 10 (3%); ▪ Placed out of state – four (1%); ▪ Placed other (e.g., family home) – two (less than 1%); and ▪ Deaths – 86 (24%). Since 3/14/14, an additional 10 individuals died, including two at BSDC, and eight in the community, including two in nursing homes. It is also important to note that the Division of Developmental Disabilities worked with the 47 individuals considered to be "medically fragile," who had been moved from BSDC in early 2009, and their guardians to identify the most integrated setting appropriate to meet their needs. Unfortunately, a number of them had died. However, others who originally had been placed in nursing facilities or hospitals had moved to more integrated settings. According to BSDC Census and Transition Data – Medically Fragile Individuals Transferred in February 2009, revised 3/14/14, the following represented their status: ▪ Total moved in early 2009 – 47; ▪ In community placement – 17 (36%); ▪ In ICF/ID community placement – eight (17%), including five individuals who returned to and continued to reside at BSDC and three individuals who resided in small ICFs/ID in the community. Of note, one of these three individuals had returned to BSDC, but subsequently moved to a community ICF/ID; ▪ In nursing facilities – two (4%); ▪ Deaths – 20 (43%), including one in 2014, three individuals in 2013, one individual in 2012, two in 2011, two in 2010, and 11 in 2009.

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Appropriateness for Placement		
B24	It is the State's determination that all residents of BSDC meet the essential eligibility requirements for placement and habilitation in integrated community settings. All residents can be served in integrated community settings when adequate protections, supports, and other necessary resources are identified as available by service coordination. The State shall ensure that this is clearly set forth in each resident's written interdisciplinary team recommendation contained within each individual's BSDC Personal Plan, or equivalent.	*Areas in which Less Oversight is Necessary* ▪ *Generally, as required by the Settlement Agreement, a statement that the individual could be served in an integrated setting with adequate protections, supports, and other necessary resources was found in individuals' Individualized Personal Plan (IPPs). Based on review of BSDC's revised IPP format, this now was included as part of the template. It read: "The IDT recognizes that given adequate protections, supports and other necessary resources [Individual's Name] could be served in an integrated setting."*
Resident Involvement and Choice		
B25	Throughout, each resident shall be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers.	*Areas in which Less Oversight is Necessary* ▪ *In reviewing IPPs, Service Coordinator notes, and transition plans, individuals and their guardians had been involved in discussions related to possible transition to the community, as well as decision-making throughout the transition process.*
B26	To foster each resident's self-determination and independence, the State shall use person-centered planning principles at every stage of the process. This shall facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs.	*Person-centered planning is also addressed with regard to Section B48 and Section C57.* *Areas Requiring Focused Effort* ▪ *Although some person-centered planning principles were being used and training modules included person-centered planning concepts, individuals' plans did not consistently show evidence that individuals' specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs had been identified, and incorporated into the plans. Overall, even when preferences, interests, abilities, and strengths were identified, teams did not follow-through with the development of specific action plans to assist individuals in achieving their goals. Occasionally, an individual's interests or preferences were noted, and incorporated into an action plan or skill acquisition goal.* ▪ *This section also requires the State to identify individuals' "deficits and support needs." Often, supports were mentioned, but not in any detail, and corresponding detailed action plans were not included. To provide just a couple of many examples, nursing care plans were incorporated*

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		verbatim into a number of IPPs. However, they did not provide details with regard to who would do what, within what timeframes or parameters, the specific documentation that needed to be maintained, or what individualized outcome measures would be used to determine if the individual was doing better or worse, or was maintaining his/her current status. Likewise, narratives mentioned behavior support plans and Points of Service (POS) plans, and teams "approved" them. However, no related action plans were included in the IPPs to ensure these plans were implemented, and that the related objectives were tracked and monitored. On a positive note, since the last review, as discussed in further detail below, the State had continued efforts to modify the IPP format and content. As discussed in other sections of this report, the IPP was a key document. In addition to the Settlement Agreement requirements related to the IPP, the 404 Regulations, by which Waiver-funded services were monitored, relied heavily on the IPP document to define the protections, services, and supports individuals required, and providers were responsible for implementing. In addition, CCSs' monitoring activities also were connected to the IPP document. It was anticipated that the new IPP format would be integrated into Therap, and that this would allow the system to generate more individualized monitoring protocols. The goal was to have an electronic IPP by the summer of 2014. Once accomplished, this should provide CCSs as well as State surveyors with important tools to conduct their monitoring and oversight activities. As noted in the last report, the BSDC QDDP Coordinator's role had been revised. Since the last review, the QDDP Support Services Team had been established, including hiring two QDDP Program Specialists to work with the QDDP Coordinator. The QDDP Coordinator was reporting to both the CEO at BSDC as well as the Transition Manager. Based on interview and document review, the QDDP Coordinator and Transition Manager worked together, and had begun to develop and revise checklist for the community IPPs and to conduct reviews of IPPs that CCSs and teams of individuals living in the community had developed. The Transition Manager had trained CCSs on the tool, and the expectation was that CCSs would begin to use the checklist as a self-assessment. In addition, hints were added to the community IPP template, and instructions were developed for the audit checklist. Given that similar efforts at BSDC had resulted in a number of improvements to the BSDC IPPs, the Independent Expert Team viewed these as positive changes. The Transition Manager and QDDP Coordinator acknowledged that although some progress already had been seen, more work was needed. The Independent Expert Team recognized that the IPP process was expected to change. However, a review was conducted of a sample of IPPs to determine if any significant changes had occurred since the last review. The findings from this review are discussed below. A review of IPPs for individuals visited in the community indicated the following, with respect to the "Areas Requiring Focused Effort" noted above:

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		▪ The "Hopes and dreams" and "Strengths and preferred activities" sections of the IPP usually included good descriptions of things that were important to the individual. ▪ The "Community Involvement" and "My day looks like this" sections of the IPP generally included personalized descriptions of opportunities and activities that reflected individuals' preferences, choices, hopes, and dreams. ▪ However, IPP Goals did not consistently include language that reflected those personal preferences, choices, hopes, and dreams. Goals usually targeted outcomes that were judged to be "Important for" the individual, but they less consistently targeted outcomes that were "Important to" the individual. ○ The IPP for Individual #419 included only two formal habilitation goals neither of which could be related to personal preferences, choices, hopes, and dreams except in the most general sense (e.g., "follow work expectations" was not an adequate reflection of the preference to "have a paying job.") The "Supports/Staff Objectives/Service Needs" sections of the IPP did include a number of objectives that were well-aligned with personal preferences, choices, hopes, and dreams (e.g., writing checks, researching phone plans, learning about transportation options, studying for a driver's test). However, because these were not included as formal programs, there appeared to be little accountability with respect to ensuring that the objectives were pursued, no description of how the skills would be taught or strengthened, nor any indication of how progress toward the objectives would be assessed. ○ The IPP for Individual #415 included three formal habilitation goals, none of which could be related to personal preferences, choices, hopes, and dreams. ○ The IPP for Individual #77 included three formal habilitation goals, none of which could be related to personal preferences, choices, hopes, and dreams. ○ The IPP for Individual #341 included two formal habilitation goals, neither of which could be related to personal preferences, choices, hopes, and dreams. ○ The IPP for Individual #400 included four formal habilitation goals, none of which could be related to personal preferences, choices, hopes, and dreams. It should be noted that the "Hope and Dreams" section of her IPP included a wish "to have more time working in the community" and one of her goals was to "develop community work skills." While a perfunctory review might suggest that this was a goal reflecting "personal preferences, choices, hopes, and dreams," in fact the focus of the goal was for her to "stay on task." Staying on task is not necessarily an inappropriate goal for an individual, but it would not constitute a reflection of personal hopes and dreams unless the individual her/himself had explicitly communicated a wish to be able to stay on task better. ○ The IPP for Individual #286 included three formal habilitation goals, none of which could be related to personal preferences, choices, hopes, and dreams. ○ An exception to the pattern noted in the above examples was the IPP for Individual #232. He reportedly had a personal goal to continue job shadowing and his IPP included the formal goal "go out into my community businesses to speak to management and inquire

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		about job shadowing." Another possible positive example was the IPP for Individual #132. She had expressed a wish to become more comfortable with the local area in which she lived, and her goals included one to participate frequently in community outings. ▪ The DDSC Individual/Family Meeting – Personal Focus Worksheet (with the instructions dated 4/2014) appeared to have good potential for supporting person-centered planning for individuals living in the community. ▪ The "Review of My Progress" section of the sample of IPPs reviewed was often difficult to interpret in any practical sense, sometimes referring to percentages, number of prompts, and short-term objective (STO) numbers with little indication as to whether the individual was better off in some way as a result of the intervention, sometimes including comments consisting of general assertions without reference to supporting data, and sometimes including much extraneous information that failed to communicate whether progress was achieved. In part, these weaknesses were a function of the poorly conceptualized and poorly specified goals and programs as referenced elsewhere in this report. In sum, while the IPPs contained "evidence that individuals' specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs" had been identified, these components were not consistently "incorporated into the plans." IPPs continued to show deficits with respect to reviews of progress and details regarding supports. This was an area that continued to require focused effort. BSDC staff reported that they had offered training to community providers in data collection with respect to habilitation programs. They also noted that, along with State Office personnel, they were working on revising the IPP process for individuals in the community by means of prompts in the IPP Template, a revised IPP Checklist, and guidelines and a process for the review of IPPs. Community Coordinator Specialists reportedly were using the IPP Checklist as a training and self-assessment tool for community providers. These efforts represented promising approaches to addressing the weaknesses in habilitation planning for individuals in the community. Although a number of positive steps had been taken, this was an area that continued to require focused effort.
B27	Each resident shall be given the opportunity to express a choice regarding placement. The State shall provide residents with choice counseling to help each resident make an informed choice; the State will provide enhanced counseling to those residents who have lived at BSDC for many years.	*This has been combined with Section B28, because both relate to informed choices regarding transition to the community, as well as follow-up to ensure the decision is an informed one.*

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B28	If any resident opposes placement, the State will document the steps taken to ensure that any individual objection is an informed one. The State shall set forth and implement individualized strategies to address concerns and objections to placement.	*Areas in which Less Oversight is Necessary* ▪ *Through the IPP process and ongoing contact with Service Coordinators, individuals were provided opportunities to express a choice regarding placement.* *Areas Requiring Focused Effort* ▪ *IPPs included a section entitled: "Individual and Guardian's position on transition outside of current living environment and responses to objections/concerns." The plans reviewed generally did not set forth concrete steps or discussion to ensure that the individual or guardian's objection to community transition was an informed one. As during past reviews, the IPPs often included statements about the individual or guardians' preference and reason for the preference, but discussion about the benefits and risks of an alternative placement were not formally documented, nor was the professional team members' opinion about whether or not a referral should be made clearly presented to the individual or guardian. Based on Service Coordinator notes, they remained in contact with individuals and guardians to discuss options, but the full team should be involved in ensuring decisions are informed ones and "set[ting] forth and implement[ing] individualized strategies to address concerns and objections to placement." In its reports, the Monitoring Team has discussed a number of different types of strategies that could be considered and individualized.* For this report, the Independent Expert Team reviewed the IPPs for five individuals, including: Individual #277, Individual #192, Individual #109, Individual #155, and Individual #268. Based on review of this small sample of IPPs, good improvement was seen in the documentation of steps taken to ensure that the individual and/or guardian's decision about community transition was an informed one. For example, in the IPPs, a list was provided of some of the providers about whom information had been sent to the guardian. In addition, the teams identified some of the specific reasons that each of the individuals and their guardians had chosen for them to remain at BSDC. In a number of instances, some specific barriers to their transitioning to the community were identified. Some good detail was provided about the specific concerns that individuals or their guardians had about transition. In addition, teams had identified some next steps, such as referral to community-based day/vocational programming or consideration of living at one of the apartments on campus. These were positive changes since the last review.
B29	Throughout the process, the State shall regularly educate residents about the community and the various community options open to them. Any written materials or presentations shall be easy for residents to understand.	*Section B29 relates to education regarding community options, which is addressed with regard to Section B28.*
B30	The State shall provide each resident with several viable	*Section B40 addresses the requirement that is also included here for the State to "provide field trips to these viable community sites and facilitate overnight stays at certain of the community residences, where*

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	placement alternatives to consider whenever possible. The State shall provide field trips to these viable community sites and facilitate overnight stays at certain of the community residences, where appropriate.	*appropriate."* *Areas in which Less Oversight is Necessary* ▪ *For individuals who had been referred for transition to the community, documentation was present to show that a variety of community options had been discussed and offered to the individuals and their guardians. This appeared to be an individualized process depending on the preferences of the individuals and/or their guardians.*
B31	Where family members and/or guardians have reservations about community placement, the State shall provide ongoing educational opportunities to such family members and/or guardians with regard to placement and programming alternatives and options. These educational opportunities shall include information about how the individual may have viable options other than living with the family members and/or guardians once discharged from BSDC. The State shall identify and address the concerns of family members and/or guardians with regard to community placement. The State shall encourage family members and/or guardians to participate, whenever possible, in residents' on-site, community home field trips.	*Areas in which Less Oversight is Necessary* ▪ *In response to the Monitoring Team's request in January 2012, the State provided a list of individuals with a status of whether or not the individual and/or guardian was opposed to transition to the community. This list appeared to include individuals currently residing at BSDC, Bridges, and nursing facilities. According to this list, their status was as follows:* ○ *Opposed to community transition – 138;* ○ *Not opposed/open to community transition – seven;* ○ *Might be open to community transition – six; and* ○ *Undergoing guardianship change – one.* ▪ *Based on documentation provided, some guardians who had been opposed changed their minds (e.g., approximately nine in 2011). This likely was due to many of the Service Coordinators' efforts to discuss options.* ▪ *Based on review of this list, as well as Service Coordinators' notes, it was clear that they were making regular contact with family members/guardians, and offering information regarding community options. They also were collecting information related to the reasons for guardians' opposition to community placement.* *Areas Requiring Focused Effort* ▪ *When guardians opposed placement, IPPs did not consistently include individualized plans to address concerns noted. Often the transition plan component of the plan stated that education about options would continue, but even when specific concerns were noted, plans were not set forth to address them.* ▪ *Based on documentation provided, it was not clear that the State had aggregated the information Service Coordinators gathered, analyzed it, and developed a plan to address the identified concerns, to the extent possible, on an individual and systemic level.* As noted above, based on a review of five sample IPPs, some included more individualized recommendations or plans to address the concerns of individuals or guardians with respect to community transition. Although this was an area in which efforts should continue, it was positive that the IPP format and guidelines prompted teams to address actions that could be helpful in individuals and their guardians learning more about community options that could meet their needs.

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Transition Plans		
B32	The State shall set forth in reasonable detail a written transition plan specifying the particular protections, supports, and services that each individual resident will or may need in order to safely and successfully transition to and live in the community. Such a transition plan shall be prepared on or before January 1, 2009, for each resident regardless of whether or not a suitable community placement is currently available.	*This is covered by and should be combined with Section B33.*
B33	Each transition plan shall be developed using person-centered planning principles. Each transition plan shall specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the resident in the alternative community setting, including their scope, frequency, and duration. Each transition plan shall include all individually-necessary protections, supports, and services, including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living. Each plan shall include	*Areas in which Less Oversight is Necessary* ▪ *Transition Plans and/or the related Individual Program Plan (IPPs) generally did "include specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports."* *Areas Requiring Focused Effort* ▪ *The State had revised its processes for transition planning. A Transitional Plan document and the IPP were to be used in combination to address the requirements for a transition plan. Conceptually, the Monitoring Team viewed such a process as acceptable, because it would allow the detail related to individualized protections, supports, and services to be included in the IPP, and the Transition Plan to address the logistics of transition process. However, in practice, although some improvements were seen with regard to recent transition plans/IPPs:* ○ *The combined Transition Plan and IPP documented did not yet "specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the resident in the alternative community setting, including their scope, frequency, and duration… including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living." The Monitoring Team has provided detailed analysis in the draft report on the community regarding what was missing from the documents.* As discussed in previous reports, a comprehensive transition planning process is important for a number of reasons. This includes, but is not limited to the need to ensure that protections, services, and supports

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	specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports.	an individual requires are provided seamlessly, and that individuals and their guardians are assured that protections, services, and supports the individual requires will be available in the community settings they select, even if they might be provided somewhat differently. Often, for guardians or individuals who are reluctant to consider transition to the community, comprehensive transition planning can be used as a tool to reduce or eliminate their concerns. The Independent Expert Team conducted a review of three individuals' "Transition Plan For" document, as well as their most recent IPP, and related assessments. These individuals were the three individuals that most recently had made transitions from BSDC or Bridges to the community, and included: Individual #419, Individual #132, and Individual #232. As indicated in previous reports, the State viewed IPPs as the backbone of the transition planning process. This was appropriate, given that IPPs should be the documents that set forth the individual's needs, and the transition plan should describe how those supports would be transitioned to the community or new setting. Individual #419 and Individual #132 had complex behavioral and psychiatric needs, and Individual #232 had complex medical needs. When taken in totality, the IPPs and transition plans submitted for these individuals generally showed a comprehensive set of protections, services, and supports. Some of the supports that their IPPs and transition plans outlined included: transition visits, training needs for new staff, staffing ratio/needs, areas in which the individual was independent or needed assistance, preferences, BSPs, Safety Plans, Points of Service Plans, health care plans, restrictions, medical needs, needs for ongoing clinical support, coordination needs between current and future practitioners, risk ratings and plans, equipment, transportation needs, employment supports, skill acquisition plans, and community integration activities. It appeared their IDTs had carefully selected providers that could offer the supports and services they required. In summary, transition planning was an area in which significant progress was seen over time. Compared to the findings from the Independent Expert's initial reviews, the most recent transition plans, when viewed in combination with individuals' IPPs, specified the majority of the "individualized protections, supports, and services needed to meet the needs and preferences of the resident in the alternative community setting, including their scope, frequency, and duration… including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living." This had become an area that the Independent Expert Team recommends requires less oversight.
B34	The State will continue to emphasize the placement of residents into smaller community homes.	*Areas in which Less Oversight is Necessary* ▪ *In the State's written materials, in interviews with staff, and in documents reviewed, a strong commitment continued to exist to assist individuals to move to smaller community settings. As of October 19, 2007, 353 individuals lived at BSDC. The following represented their status as of March*

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		29, 2012: ○ *A total of 137 individuals were in settings outside of BSDC, including:* ▪ *Of these, 98 (72%) individuals were living in small community-based developmental disability settings, or with family. In upcoming reports, based on information the State will provide, a description will be included of the size of the homes in which individuals are living;* ▪ *A total of 21 (15%) were living in other ICFs/DD, including eight individuals who were living in large ICFs/ID;* ▪ *Thirteen (9%) were living in skilled nursing facilities;* ▪ *Two (1%) were living out-of-state;* ▪ *Two were living in other settings (e.g., with family) (1%); and* ▪ *One individual (1%) was being treated at an acute mental health facility.* ○ *A total of 70 individuals had died.* ○ *Ten individuals were served in the Bridges program;* ○ *At BSDC, 136 individuals remained.* ▪ *As of March 29, 2012, approximately four individuals at BSDC, one individual in a nursing home, two individuals from Bridges, and one individual from a Regional Center were in the process of transitioning to the community, for a total of eight individuals.* ▪ *Service Coordinators continued to be assigned to all individuals at BSDC, and in more restrictive settings in the community, such as nursing homes and large ICFs/DD. Part of their role was to continue to provide information about community options to individuals and their guardians.* ▪ *The homes in the community that the Monitoring Team visited generally were integrated into neighborhoods, providing the opportunity for individuals to be members of communities, as well as to participate in household activities. For the eight individual living in a privately-operated ICF/ID, it appeared the State was continuing to offer them alternatives, but the individuals and/or their guardians had chosen this option as opposed to a smaller community setting.*
B35	In developing these plans, the State will avoid placing residents into nursing homes or other institutional settings whenever possible. The parties recognize that nursing homes are often not well-suited to provide needed habilitation to persons with developmental disabilities. The State will develop and implement a systemic plan to develop, through the Home and Community-Based Waiver or	*Areas Requiring Focused Effort – Although numerous efforts had been made in this area, due to the importance of continued focus to reduce to the extent possible the numbers of individuals residing in nursing homes and ensure that while in such settings they receive the supports they require, this is an area that the Independent Expert will continue to review.* ▪ *According to the census list updated through 3/29/12, 13 individuals who had resided at BSDC since October 19, 2007 were residing in in-state nursing homes. One additional individual was living in an out-of-state nursing home. Based on the Monitoring Team's ongoing review of individuals in nursing homes, it was clear that DDD staff had made regular and ongoing efforts to offer community options to individuals and their guardians. Although DDD staff had not given up, at this juncture, all guardians, except one, were opposed to moving individuals from the nursing homes. The one individual, whose guardian recently had changed his mind, was in the transition process.* ▪ *Utilizing the resources at BSDC, individuals residing in nursing homes had undergone assessments to determine what their needs were, and recommendations had been offered to strengthen the supports*

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	otherwise, integrated community alternatives to nursing homes for all residents with unique or more intense and complex health care needs.	*they were receiving.* ▪ *Notably, since the last review, DDD had offered to provide day or habilitation supports to individuals in nursing homes. Based on interview with staff, the Service Coordinator(s) assigned to individuals had contacted all of their guardians to offer the supports. Most, if not all, had declined. State staff indicated that they would continue working with guardians. In addition, the Level II screenings, which were used to determine if an individual with mental retardation that was found eligible for nursing home services also required specialized services, were under review to determine if changes needed to be made to the process.* As of March 14, 2014, 10 individuals the Settlement Agreement covers resided in nursing facilities in Nebraska, and one lived in an out-of-state nursing home. Based on conversations with State staff, efforts were continuing to offer community-based options to individuals and their guardians. However, at the time of the Independent Expert Team's onsite review, none of these individuals were planning transitions. During the onsite reviews, the Independent Expert Team visited one individual living in a nursing home. As noted in the "Areas Requiring Focused Efforts," it was agreed the Independent Expert Team would continue to review this area based on the importance of continuing to reduce the numbers of individuals living in nursing facilities. The State continued to make efforts in this regard. However, guardians were generally opposed to transition. For example, during this community review, one of the individuals visited (i.e., Individual #33), resided in a nursing facility. Individual #33's Community Coordination Specialist continued to make recommendations for transition to another residential facility and a day program that would provide opportunities for habilitation. However, Individual #33's guardian was opposed to any transition to another residential facility and/or attendance at a day program. In response to a request from DOJ, the State provided a summary of efforts since the inception of the Settlement Agreement to transition individuals from nursing facilities to more integrated community settings. In addition to summarizing some of the overall efforts to educate guardians about community options, the State provided some specific examples of individuals that had transitioned out of nursing facilities, as well specific efforts with individuals and their guardians who choose to remain in nursing facilities. The following provide just a few examples that are representative of the significant efforts in which the State engaged: ▪ Through the efforts of the CCS, Individual #369's parents toured a small ICF/ID and agreed to move him from a nursing facility. His CCS reported that his parents were pleased with the smaller home and one-to-one attention. In fact, his parents spoke to a few people about Individual #369's successful experience with transition. ▪ Through the efforts of the CCS, Individual #285's guardian toured a CDD, and expressed interest in him moving. The nursing facility attempted to have the guardian removed to prevent the move, and proposed a nursing facility staff member as the replacement guardian. With the assistance of the CCS, the guardian attended the hearing, and the judge kept the original guardian in place. Individual #285 moved to a MSU, and is described as "thriving."

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		▪ Individual #123's guardian/brother was originally adamant that she not move from the nursing facility. Through the CCS's persistence, he agreed to talk to Individual #369's parents, who helped convince Individual #123's guardian to tour a group home. Although her guardian was not unhappy with the nursing facility, he was impressed with the group home. She lived there until she passed away in 2014. Reportedly, her guardian as well as her mother appreciated the activities in which she was involved, and the one-to-one attention. Overall, activities included CCS' ongoing communication with individuals and their guardians, sharing of information about existing and new community options, pairing of guardians that had successful experiences with ones who were reluctant to consider community transition, and involvement of the Medical Review Team, as appropriate, to discuss alternatives. As also noted in previous reports, it was positive that DDD had attempted to evaluate and make recommendations regarding the healthcare supports the nursing facilities were providing. It was unfortunate that many guardians of individuals in nursing facilities had declined further involvement of DDD in working through the recommendations made. In addition, the State had offered to pay for DDD-funded day or habilitation supports for individuals residing in nursing facilities. However, guardians had generally declined this offer as well.
B36	Each transition plan shall identify the date the transition can occur, as well as timeframes for completion of needed steps to effect the transition. Each transition plan shall include the name of the person or entity responsible for: commencing transition planning; identifying community providers and other protections, supports, and services; connecting the resident with community providers; and assisting in transition activities as necessary. The responsible person or entity shall be experienced and capable of performing these functions.	*Section B33 addresses the quality of the information included in the transition plans and IPPs. Specifically with regard to the identification of timeframes for completion and persons responsible:* *<u>Areas Requiring Focused Effort</u>* ▪ *In recent transition plans, some improvements were seen in the identification of the name or title of the person responsible, particularly for State staff. However, the name of the provider agency often was substituted for the name or title of the specific person responsible. It was agreed that the State would identify one person who the provider agency considers its coordinator, rather than identifying a variety of people within the provider agency.* ▪ *In addition, because the dates the transition plans were drafted were not always clear, it was difficult to determine, but the wording for many of them described events that had happened, as opposed to a plan about what needed to happen.* As noted above, improvements were seen with regard to the most recent transition plans.
B37	Each transition plan shall be developed sufficiently prior to potential discharge so as to enable the careful development and	*The quality of the teams' efforts to develop transition plans and "work closely with pertinent community agencies so that the protections, supports, and services that the resident needs are developed and in place at the alternate site prior to the resident's discharge" are discussed with regard to Section B33. With regard to teams developing transition plans "sufficiently prior to potential discharge so as to enable the careful*

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	implementation of needed actions to occur before, during, and after the transition. This shall include identifying and overcoming, whenever possible, any barriers to transition. The State shall work closely with pertinent community agencies so that the protections, supports, and services that the resident needs are developed and in place at the alternate site prior to the resident's discharge.	*development and implementation of needed actions to occur before, during, and after the transition:"* *Areas in which Less Oversight is Necessary* ▪ *In reviewing the sample of transition plans, it appeared that efforts to begin the transition planning process earlier continued. Specifically, the new format "Transition Plan for…" was to be developed as part of the annual IPP meeting, and it would be updated as changes occurred and/or at quarterly or annual IPP meetings.* ▪ *Based on recent record reviews, once an individual and his/her guardian selected potential community providers, Service Coordinators' notes, as well as the Pre-Transition Activities Completed, and Transition Summary – Items Completed generally documented ongoing collaboration with community providers to develop appropriate supports, and overcome barriers. It should be noted the Transition Plans should be dated, including dates on which updates were made.*
B38	The State shall update the transition plans as needed throughout the planning and transition process based on new information and/or developments.	*Areas in which Less Oversight is Necessary* ▪ *Based on recent record reviews, although Transition Plans often were undated, as noted above with regard to Section B37, Service Coordinators' notes, as well as the Pre-Transition Activities Completed, and Transition Summary – Items Completed generally documented ongoing collaboration between teams and community providers, included modifications to plans, when circumstances changed.*
B39	In developing the transition plans, the State shall attempt to locate community alternatives in regions based upon the presence of persons significant to the resident, including parents, siblings, other relatives, or close friends, where such efforts are consistent with the individual's desires.	*Areas in which Less Oversight is Necessary* ▪ *Based on recent as well as previous reviews, documentation was found to show that Service Coordinators and individuals' teams worked diligently to identify appropriate supports in areas of the State that were the preferences of the individuals, their guardians, and/or family members.*
B40	The State agrees to provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each resident. The State shall	*Areas in which Less Oversight is Necessary* ▪ *The format for transition plans included a prompt for the teams to "Arrange for pre-transition visits." Based on recent record reviews, somewhere in the transition documentation, mention was found regarding planning for or the occurrence of pre-transition visits, or, reasons such visits would not be appropriate. These often included day and overnight visits to the various proposed homes and day programs. They appeared to be individualized. In some cases, multiple visits were made to provide the individual time to become familiar with staff and the environment, and in others fewer visits were made due to the stress extra visits might cause.*

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	modify the transition plans, as needed, based on these community visits.	
B41	Each individual transition plan shall establish a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the individual are being met. Each plan shall specify more regular visits in the days and weeks after any initial placement.	*Areas in which Less Oversight is Necessary* ▪ *Based on recent record reviews, Transition Plans had begun to include a schedule of monitoring visits. All of them included the standard schedule of once weekly for the first six months. It will be important for these schedules to be individualized for each person transitioning to the community from BSDC or Bridges.*
Implementation of Transition Plans		
B42	For those residents who do not oppose community placement, the State shall implement, in an expeditious manner, the transition plans that can be reasonably accommodated, by transferring each resident to an adequate and appropriate alternative community setting pursuant to the details set forth in each transition plan.	*In terms of the implementation of transition plans, as noted above, the State had identified the Transition Plan and the IPP as the documents that together formed the transition plan the Settlement Agreement required. At the time of the review, the State's process and protocol/tool for monitoring individuals' services after their transition was identical to the ongoing monitoring that occurred for all individuals (i.e., no specific post-move monitoring form had been developed to specifically determine if transition plan/IPP requirements had been met). The adequacy of individuals' protections, supports, and services after they transitioned is discussed in detail with regard to Section B48, as is Service Coordinators' monitoring of these supports.* *Areas in which Less Oversight is Necessary* ▪ *When an individual's team decided to refer him/her and the individual did not oppose transition to the community, records consistently showed that teams made efforts to expedite the transition. Individuals generally transitioned to the community in a reasonable amount of time, and no waiting list for funding for individuals wanting to move from BSDC or Bridges to the community existed.*
Developing and Expanding Community Capacity		
B43	The State shall take effective steps to support and expand service and provider capacity in the community so as to better serve residents placed and to be placed in the community. This shall include, but not be limited to, developing community capacity with regard to: housing and residential services; health care and other professional services; specialty health care services; therapy services;	*Section B43 and B44 are closely tied together. In the descriptions that follow, an attempt has been made to separate the expansion of provider capacity (Section B43) from the provision of outreach services or technical assistance (B44) with the intention of expanding capacity. However, the two often overlap.* **Housing and Residential Services** *Areas in which Less Oversight is Necessary* ▪ *In general, the State had expanded options through recruitment of new community providers and expansion of funding options. Although work continued to broaden the community provider base, an array of providers was available that had the capacity to provide housing and residential services to individuals with varied needs. As discussed below, the quality of the supports provided varied, but different residential options were available to individuals.* ▪ *For one individual, when appropriate residential services could not be located within Nebraska, the*

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	communication and mobility supports; and psychological, behavioral, and psychiatric services.	*State identified a residential provider out-of-state that could address his needs.* Although this was an area requiring less oversight, it is important to note as was detailed in previous reports, since the inception of the Settlement Agreement, the State worked to expand the community options available to individuals, including both residential and day/vocational opportunities. This had occurred through the expansion of the options available through Waiver-funded services, the development of small ICFs/ID, the expansion of the community provider-base in the State, as well as work with providers interested in changing their service delivery models (e.g., from a work center or day treatment model to programs offering vocational as well as other integrated options for activities). Based on the information the State provided in its DDD Updates, in 2009, there were 25 specialized providers (i.e., those certified under the 404 regulations to provide community services). Since then, 35 have been newly certified. Some of specialized providers are certified to provide supports in more than one location, resulting in a total of 87 certified programs. On an ongoing basis, the State assesses the need to add to the provider network. The following provide some examples of how this expanded array of housing and residential services was positively impacting individuals' lives: ▪ Individuals visited during this most recent onsite review were living in a variety of contexts, generally representing an appropriate range of alternatives and allowing providers to serve individuals with a wide range of support needs. ▪ At the time of the Independent Expert Team previous review, the individuals in the Bridges program were expected to move into newly constructed homes during the coming weeks. During the most recent onsite review, the Monitoring Team again visited the newly constructed homes that the individuals at Bridges now had moved into. In stark contrast to the previous location of the Bridges program on the grounds of a mostly uninhabited old mental health hospital, the new homes were lovely and the individuals living there appeared to be benefitting from the transition to residences that allowed for more opportunities to learn and practice more independent living skills. The homes were an example of the positive results arising from the State's firm commitment, sustained advocacy, thoughtful planning, and careful allocation of resources. In sum, the range of community living alternatives appeared to continue to expand, offering a variety of available levels of support to match the needs of individuals. **Behavioral/Psychological Services** *Areas in which Less Oversight is Necessary* ▪ *The State had modified and expanded its Home and Community-Based Services (HCB) Waiver to increase options available to individuals with complex behavioral needs. In addition, the State had used "exception" funding through contracts with specific providers to fund supports for individuals requiring more intensive behavioral supports.*

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		▪ *Due to gaps in the Nebraska behavioral health system in relation to the provision of long-term residential services to individuals with co-existing mental health diagnoses and intellectual disability, DDD was funding/providing to and/or developing residential supports for some individuals who formerly lived at BSDC that needed this configuration of supports.* ▪ *For situations in which the State's contracted behavioral services outreach team was involved, it generally appeared that they were providing valuable input that was beneficial to individuals and community providers. The model they used involved working closely with the individuals' teams, which was assisting in expanding capacity in this area.* *Areas Requiring Focused Effort* ▪ *Although improvements were seen, further expansion was needed of provider capacity with regard to the development and provision of behavior supports, including engagement of competent professionals in behavioral assessment and intervention, resulting in improved functional assessments, Behavior Support Plans, and Safety Plans.* Functional Behavior Assessments and Behavior Support Plans BSPs for each of the individuals the Psychologist on the Independent Expert Team visited during this review were reviewed to assess providers' capacity to undertake adequate functional behavior assessment and to develop behavior supports on the basis of such assessment. FBA documents, when produced by provider staff generally were quite weak. Examples below illustrate deficits in behavioral assessment observed during this review and are relatively consistent with previous observations. ▪ The FBA for Individual #419 was based on the O'Neil and Horner Functional Assessment Interview. The portions of the interview that were completed were generally appropriate and instructive. The FBA however, was incomplete, including: a) it lacked a conclusion, that is, there was no statement of hypothesis regarding the function(s) of the target behavior; and b) there was no indication of how any identified function led to the selection of replacement behaviors. Further, the identified replacement behaviors did not match the replacement behaviors identified in the individual's Positive Support Program and, indeed, the FBA did not appear to have influenced the development of the Program. ▪ The FBA for Individual #341 was conducted by provider staff and was quite weak. As noted in the previous report, the FBA: ○ "[D]id not represent a functional assessment (or a functional analysis) as those terms are currently understood in the behavioral assessment and treatment literature (i.e., the 'functions' listed were 'Emotional… list underlying irrational belief' and 'Deliberate… List all the social needs the behavior replaces'). Completion of the checklists did not reflect an adequate grasp of the principles of functional assessment… [and] revealed an idiosyncratic and unproductive understanding of functional behavior assessment. The documents suggested that the provider needed access to more behavioral assessment

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		and intervention expertise and supported the State's initiative to make such expertise available through a contract agency." ○ The agency contracted by the State to conduct FBA/BSP development had reportedly recently begun observing Individual #341, a process that will yield a new FBA and BSP and will include staff training in implementing the BSP. ▪ The FBA for Individual #417 was conducted by provider staff and was quite weak. It did not provide an adequate definition of the target behavior, "Inappropriate social skills;" it did not include any formal approach to functional assessment; it did not identify any replacement behavior (the Replacement behavior section of the document included only a list of the behaviors of concern and some suggestions about how to respond). Her IPP included mention of completion of a "QAFB [sic]" and identified the function of "attention" for her maladaptive behaviors. However, neither the function nor the identified maladaptive behaviors were referenced in her BSP. ▪ The FBA for Individual #400 was conducted by provider staff and was relatively weak. It included several statements of hypothesis regarding the function of her challenging behaviors, but no indication as to how those hypotheses were arrived at. There was no indication of any formal assessment procedures that would constitute adequate functional behavioral assessment. ▪ The FBA for Individual #132 was incorporated into a more extensive Community-Based Evaluation. It was relatively minimalist and referenced results of the QABF (staff-report checklists), but did not refer to any direct observation of behavior. The exceptions to the above (i.e., adequate FBA documents) were most often the result of contracted agencies' efforts. ▪ A member of the BSDC Behavior Support Team conducted the FBA for Individual #415, apparently as one of several a contract agency completed to support improved behavioral assessment and treatment. The assessment followed an appropriately comprehensive outline, included generally accepted approaches to information gathering, and yielded findings that were judged to be logical and helpful. Of note, provider staff had apparently conducted an earlier FBA. It was incomplete in that: a) it lacked a conclusion, that is, there was no statement of hypothesis regarding the function(s) of the target behavior; and b) there was no indication of how any identified function led to the selection of replacement behavior. The identified "replacement behavior" was not a behavior, but a statement about how behavior change might positively affect the individual. Further, the "replacement behavior" did not match the replacement behaviors identified in the individual's Positive Support Program. ▪ Community provider staff conducted the FBA for Individual #77 and it appeared to be technically adequate. The document included a note observing that two external provider agencies had consulted regarding this individual and had agreed with the reported results. ▪ In response to the pre-review document request, provider staff indicated that the agency was in the process of developing a new FBA and BSP for Individual #286. Subsequently, a copy of the newly-completed FBA was provided for review. The FBA was completed as part of the contracted

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		service to support providers in developing improved behavioral assessment and treatment services. It employed a reasonable methodology and yielded data that appeared to be useful in characterizing the functions and environmental features associated with target behaviors. This document could be considered a reasonable model of an adequate FBA. Some of the Behavior Support Plans were, similarly, quite weak. ▪ The BSP for Individual #419 identified replacement behaviors that appeared to be appropriate and logically related to his target behaviors and included methods for how the replacement behaviors would be prompted and reinforced and, in one case, how the skill would be taught. However, as noted above, the goal and objectives ("Tasks") were not consistent with the replacement behaviors identified in the FBA. ▪ In part, as a result of the limitations of the FBA, the BSP for Individual #341 had some important deficiencies. For example, while the replacement behaviors did not appear inappropriate, the rationale for selecting these behaviors was not provided (i.e., no connection to the functional behavior assessment). The "Acceleration Feedback" section of the BSP included some instructions to staff regarding environmental supports and some prompts for replacement behaviors, but the BSP lacked any active teaching intervention. The "Acceleration" and "Deceleration" behaviors included in his BSP did not match those identified on page 13 of his IPP, and neither matched the "Steps" listed under the goals for his BSP program on pages 15 and 16 of his IPP. ▪ The BSP for Individual #417 did not include any replacement behavior. Rather, the "replacement behavior" listed in the BSP was defined as refraining from the target behaviors. ▪ The BSP for Individual #400 contained the goal: "practice interacting appropriately with others." While the goal was not clearly defined, it appeared that the intent was to encourage skills such as waiting her turn to speak and respecting personal space. There was no clear intervention to teach the skills, but the plan alluded to having her "practice ways to socialize with others…" Some BSPs showed indications of more adequate behavior intervention planning: ▪ A member of the BSDC Behavior Support Team prepared a BSP for Individual #415, apparently as one of several that a contract agency completed to support improved behavioral assessment and treatment. It followed a reasonable outline and was judged to be technically adequate. This BSP was included, in materials the provider submitted, as an attachment to the Positive Support Program for the individual. This was somewhat confusing in that, while both documents identified the goal as "will demonstrate pro-social behaviors," the definition of what constituted pro-social behaviors appeared to differ substantially. The BSP definition was "appropriate requests for attention, escape or breaks, and items or activities," while in the Positive Support Program, the goal of "pro-social behaviors" was elaborated in the program tasks and included "show his Relapse Prevention Plan," "complete his Self-Evaluation Form," "act respectfully toward others," "initiate ten minutes of table talk," and "plan the week's activities in advance." These tasks might be appropriate habilitation activities for the individual, but they were unrelated to

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		the Functional Behavioral Assessment. Further, the Teaching Methods in the Positive Support Program, in addition to the method for "Reinforcing Appropriate/Replacement Behavior" from the BSP, also included a wide range of other material, which appeared to be helpful in constructing a clinical picture of the individual, but much of which was not clearly related to the behavior goals. As a result, the Positive Support Program was confusing and it was difficult to see how adherence to the program could be adequately assessed. Part of this confusion appeared to be a function of forcing somewhat disparate material into a Therap format that was designed for some other purpose. ▪ The BSP for Individual #77 appeared generally appropriate in terms of emphasis on positive behaviors that might serve to replace target behaviors, although teaching methods relied primarily on prompting, modeling, and reinforcement (as opposed to direct instruction and rehearsal), but that might be a clinically sensible choice in this case. ▪ The BSP for Individual #132 was generally appropriate to the target behavior (binge eating). Although this individual had a significant history of maladaptive behaviors, no such behaviors were observed during a baseline data collection period for the BSP (with the exception of binge eating). Thus, appropriately, the maladaptive behaviors from her history were not addressed in her BSP. She did have a safety plan for how support staff should respond to those behaviors should they recur. ▪ The BSP for Individual #286 in effect at the time of the review was not provided for review. Staff indicated that the agency was in the process of developing a new FBA and BSP. The new BSP was completed as part of the contracted service to support providers in developing improved behavioral assessment and treatment services and was subsequently provided for review. The BSP included a replacement behavior that was derived from the data in the FBA. Intervention approaches included prompting and reinforcing the replacement behavior, but did not include an active teaching component. The Team Behavioral Consultation service continued to provide consultation to providers to address the needs of individuals with significant behavioral challenges. At the time of the last review, the State had contracted with an agency to conduct 50 FBAs, and develop and train staff on BSPs for individuals served by a number of providers around the state. The goal of this initiative was that individuals would have improved behavioral assessment and intervention services, but also that provider capacity to conduct these services independently would be improved in that staff members would gain expertise through participation in the process. The initiative was slowed due to staffing changes at the contracted agency, but as of May 2013, the initiative had been re-started and was still underway at the time of the present review. As noted above, positive results of this initiative were beginning to manifest themselves. In addition, BSDC Behavior Support Team (BST) staff reported they were providing monthly training sessions in community settings to support development of providers' capacity with respect to Functional

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		Behavior Assessment. Sign-in sheets for training sessions held in October 2013 through March 2014 were provided for review. There were a total of 134 participants across five training sessions. BST members reportedly also were receiving requests from community providers to review behavioral treatment plans. The Functional Behavior Assessment training packet provided for review appeared to offer a sound basis for training provider staff in conducting functional behavior assessments. In July 2013, the agency with whom the State contracted its ITMS services had instituted a training initiative, offering a series of community-based training sessions on topics such as "Self-care and boundaries for staff…," "Serving Individuals with Co-Occurring ID/DD and Mental Illness," and "Conducting Serious Incident Investigations." A schedule of planned monthly training workshops through 2014 was provided. In sum, the FBAs and BSPs for some individuals included in the sample for this review were improved. These improvements often were a result of the contributions of contracted personnel from outside the provider agency. However, some continued to be substandard and this finding emphasizes the need for continued technical assistance to community providers and continued efforts to increase the capacity for adequate behavioral assessment and treatment in the community. In the DDD Updates, the State recognized the need for ongoing training and technical assistance, and indicated: "the Division intends to offer monthly trainings through the end of 2014. The BSDC Team is developing an advanced level training for people who have background in FBA and BSP. The advanced level training will address requests from provider agencies for the opportunity to gain practical experience in applying the knowledge gained during the first training session addressing several case studies while benefitting from professional guidance by the BSDC trainers." <u>Safety Plans</u> Safety plans for individuals visited on this review were generally improved, compared to some seen previously. For example: ▪ The Safety Plan for Individual #419 was extensive and detailed, and was incorporated into his IPP under "Safety Needs" as well as provided as a separate program. There is some concern that it was too long and detailed to be helpful when there might be a need for a quick review. The provider might wish to consider developing a summary version that can be more easily accessed and that contains essential details regarding preventing and responding to behaviors that constitute safety concerns. ▪ The Safety Plan for Individual #77 was relatively clear and concise and appeared to be adequate. Some weaknesses in Safety Plans were still noted. For example: ▪ The Safety Plan for Individual #415 also was extensive and detailed, and included much material that could be considered general good practice with all individuals with developmental disabilities and behavior challenges, but that might not be essential to include in a Safety Plan. There was significant concern that a document this long would not be useful, or used, to guide

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		staff persons' behavior. Further, in this case, there was evidence that this concern was warranted. In the Residential Supervision/Monitoring sections, the statement appeared: "When I am in my bedroom during awake hours, staff will complete room checks approximately every" but the statement was not completed to tell staff how frequently checks should occur. This same lapse occurred five more times in the Residential Supervision/Monitoring section, and four times in the Vocational Supervision/Monitoring section. This lapse was concerning in light of the importance of supervision for this individual, but it also served as an illustration of the point that, when a document becomes this long and involved it will not be read carefully, nor can it be counted on to guide staff persons' behavior. Finally, once sound BSPs are in place, it will be important to support providers with means of monitoring treatment integrity across day and residential settings. **Psychiatric Services** *Areas in which Less Oversight is Necessary* ▪ *The psychiatrists from BSDC were following a number of individuals that had lived at BSDC as of October 19, 2007 and had since moved to the community. This had expanded capacity with regard to the provision of psychiatric supports by psychiatrists with experience with individuals with coexisting mental health diagnoses and intellectual disabilities.* ▪ *The State had made efforts to reach out to community psychiatrists to offer technical assistance.* ▪ *DDD had funded a short-term community-based crisis intervention/evaluation home, which had expanded its ability to support individuals requiring more intensive psychiatric and/or behavioral assessment, and to develop and implement plans that could be transitioned with the individual to a long-term residential program.* *Areas Requiring Focused Effort* ▪ *Given that extremely limited information has been provided regarding the psychiatric treatment provided to individuals followed by community psychiatrists (i.e., psychiatrists other than the BSDC psychiatrists following individuals in the community), it is difficult for the Monitoring Team to provide information about the capacity of this system or any need for expansion. Psychiatrists or Nurse Practitioners with clinical experience were following individuals in sample records reviewed, but the quality of these supports was difficult to determine.* ▪ *In past reviews, issues had been noted with regard to the capacity of the community system to provide adequate emergency psychiatric services and/or inpatient evaluation and treatment to individuals. DDD had made efforts to work with community providers to develop Safety Plans that included the identification of emergency service providers that would be used if a crisis arose. During the most recent review, this issue did not specifically surface. However, it remained unclear if expansion of these services were necessary (e.g., development of a unit or resource for the completion of emergency or inpatient evaluations and treatment).* ▪ *During the most recent review, staff from the Medicaid and Long-Term Care Division and DDD*

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		reported on efforts underway to develop a request for proposals and gain approval from CMS to provide behavioral health services under a managed care system to individuals eligible for Medicaid. This would include many of the individuals the Settlement Agreement covers. Some of the potential benefits of such a system could be improved coordination of care to ensure individuals' needs were met, more controls over the use of medications, additional opportunities for training and building capacity of providers to address the needs of individuals with co-existing intellectual disabilities and mental health diagnoses, and improved ability to use data effectively to manage care. Based on the discussions, extensive coordination had occurred between the Medicaid Division and DDD, as well as other divisions. At the time of the review, this remained in the development phase. The goal was to have it operational by July 2013. <u>Medical Review Team</u> Prior reports have described how the State developed a Medical/Nursing Review Team (MRT) to assess the care being provided to individuals residing in the community and to make recommendations if warranted, providing their expertise. The BSDC Medical Director described the status of this to a member of the Independent Expert Team. There were two nurses involved, reporting to him. They were working on clarifying the status of the recommendations that had been made by the neurologist who had formerly been involved with the team. Another priority was their going out to review high-risk individuals and reassess them. Amongst other functions, the State saw this as a way to address concerns with regard to polypharmacy and high doses of psychiatric medicines, both of which were being considered "high risk" indicators. The annual goal of the MRT was to review everyone living in the community that the Settlement Agreement covers, whatever their level of risk. The Medical Director described "quite a bit of cooperation" by community providers and that community providers were reaching out the team for help. This was a positive step. During this review, the psychiatrist on the Independent Expert Team saw six individuals who had had the Nursing Care Reviews. During the exit meeting, the psychiatrist on the Independent Expert Team also described an intervention he thought the Medical Review Team made, but this was evidently in error. When Individual #419 transitioned into the community from Bridges, his blood pressure was initially not being monitored. The reviewer was told nurses, who set up appropriate monitoring, noted this oversight. The reviewer thought this referred to an action of the MRT. However, in response to a request for their formal report, the member of the Independent Expert Team was told the individual had not yet had a Nursing Care Review as he had just transitioned into the community. Evidently, the provider agency's nurse had identified the issue and made the needed changes described above. For the six individuals seen for this visit whom the MRT had reviewed, the team made suggestions that were or would be helpful to the individuals' psychopharmacologic management: ▪ For example, on 3/26/14, the MRT team recommended Individual #417's team consider a DD Psychiatric consultation, which seemed reasonable to the reviewer, as the individual was on antipsychotic polypharmacy and had significant probable medication side effects.

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		Some concerns were noted: ▪ Individual #415 was prescribed Seroquel and Depakote. The MRT nurse advised laboratory monitoring as per the BSDC protocol (which the Independent Expert Team viewed as thorough) and the provider agency made sure the primary care physician (PCP) ordered these tests. The MRT nurse also advised regularly scheduled abnormal movement screening. It was not clear who was to do these, though. She appeared to suggest the PCP do these, as after listing that screening and various recommended blood tests, she wrote: "review these for consideration by primary care physician." It did not seem to the reviewer the PCP was the best medical provider to carry these out, these being more in the purview of the psychopharmacologist. ▪ The MRT advised important monitoring for Individual #400. She was a 24-year-old woman who was prescribed two antipsychotics, Clozapine and Trilafon. The MRT advised metabolic monitoring (lipids, blood glucose) required for the clozapine, which the community provider team had the neurologist do. The individual had been taking the antipsychotic Trilafon at 52 milligrams (mg) a day, a very high dose, for at least seven years, though she had been doing well behaviorally, evidently with guardian input with regards to her medication regimen. This dose of that medicine for such a prolonged period put her at a high risk of developing tardive dyskinesia (abnormal potentially irreversible involuntary movements, caused by antipsychotic medications). The MRT noted that Individual #400 had evidently not been receiving the required screening. Setting up this regular monitoring was essential, as the syndrome is more likely to be reversed if picked up early and managed appropriately. As of the Independent Expert Team's April 2014 visit, the screening had not yet been set up. The team was waiting for a response from her neurologist. Again, it was not clear why they had not involved the psychopharmacologist in this discussion. In the 3/4/14 Care Review Follow-Up Report, there was an error found. The MRT had requested a Dilantin level. According to the Follow-Up Report: "Her dilantin level was slightly low at eight [normal: 10-20] and her dilantin was subsequently increased to 100mg bid [twice a day]." Based on review of documentation, in fact, the level had been a bit lower, at six. On the laboratory report someone (signature illegible) had written to increase her Dilantin to 100 mg bid. Someone else wrote below this that 200 mg a day was in fact the dose she was already taking. Below that, the first physician wrote that that the dose should be continued at 200 mg a day. These notes were not dated, but the laboratory report was from 1/8/14, and it was apparently faxed with the above comments to the provider agency on 1/14/14. Someone wrote on the form that on 1/15/14, they talked with Individual #400's neurologist, who felt that the dose should continue at 200 mg a day and that, as she was seizure-free there was no need to repeat the Dilantin level. In sum, the MRT had provided an important recommendation regarding the need to monitor for tardive dyskinesia. However, it remained unclear what the psychopharmacologist's role was, and the information related to Dilantin levels showed some confusion regarding her current dose, as well as standards of practice for an individual with low blood levels, but no seizures. One of the MRT reports appeared to have overlooked important aspects of monitoring treatment:

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		▪ On 11/4/13, according to her note, when she assessed the care of Individual #286, the reviewing nurse only looked at the most recent laboratory tests. As expanded upon below in relation to Section B48, while the liver tests of 10/10/13 were normal, these values were in conflict with the abnormally high levels done both before (2/28/13 and 7/9/13) and subsequent to (1/9/14) the report. There was no mention in the report that the individual had Hepatitis C, and was having regular blood tests and episodic liver ultrasounds, or of the possibility that recent liver abnormalities might have been caused by the individual's psychiatric medicines. She also wrote that the individual's last platelet level was borderline low at 120,000 (normal being 150,000 to 350,000), not noting that the platelet count had recently been low enough, 55,000 on 7/12/13, to potentially lead to excessive bleeding with minor trauma, a significant issue in a gentleman such as Individual #286 with a history of self-inflicted head trauma. The reviewing nurse also did not advise that the individual needed to have his cholesterol checked, as he was taking Zyprexa. Perhaps she had seen a recent value, but there was none in the laboratory studies, from 2/7/13 through 2/20/14, made available to the Independent Expert Team. She also did not suggest the need for an electrocardiogram (EKG), which the BSDC Medication Minimum Monitoring Requirements advised be done annually in individuals taking Zyprexa. Annual EKG monitoring is generally the standard approach. <u>Effort to Develop a Managed Care System</u> As noted in the last report, a contract had been awarded for the Behavioral Health Managed Care contract for individuals receiving Medicaid. This included a number of individuals the Settlement Agreement covers. DDD staff reported that the selected provider had made some important contacts with DDD staff, as well as DDD's contracted agencies responsible for providing Team Behavioral Consultation Services and for assisting in the development of Functional Assessments and Behavior Support Plans, and was working with them to develop models that would benefit individuals with intellectual and developmental disabilities. This was encouraging, because it showed an initial recognition for the need for preventative services like those provided through the Team Behavioral Consultation model. **Healthcare (i.e., Medical, Nursing, and Physical and Nutritional Management)** *<u>Areas in which Less Oversight is Necessary</u>* ▪ *The State had modified and expanded its Home and Community-Based Services (HCB) Waiver to increase options available to individuals with complex medical needs. Although the State was working on criteria for individual eligibility and the provider requirements, waiver funds were being used for medical risk services via contract addendums as pilot projects. Other funding also was used to fund Medical Services Units (MSUs), and small ICFs/ID.* ▪ *With the licensing of a clinic at BSDC, DDD was able to conduct assessments/evaluations, and in some cases provide direct medical or dental care to individuals living in the community.* *<u>Areas Requiring Focused Effort</u>* ▪ *Many individuals that had lived at BSDC as of October 19, 2007 required assistance with the*

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		coordination of healthcare, and required day-to-day implementation of supports to ensure their health (i.e., implementation of nursing care plans or healthcare protocols). However, issues related to the availability of nurses with adequate time to address the issues (e.g., in CDDs), and/or nurses with an adequate knowledgebase about the provision of supports to individuals with intellectual disabilities resulted in the provision of inadequate supports. The Monitoring Team noted these inadequacies, as well as the Morality Review Committee in a number its reports. ▪ *Similarly, many of the individuals that had lived at BSDC as of October 19, 2007 required coordinated physical and nutritional management supports, ongoing staff training, and monitoring of such supports. Within the community system, obtaining such services of adequate quality was often difficult. Capacity issues appeared to relate to limited numbers of community therapists with expertise in working with individuals with intellectual disabilities, and lack of a model and/or funding for a coordinated/integrated system for providing supports (e.g., a physical and nutritional support team model).* ▪ *Increased expertise was needed in the development of communication training programs and other interventions to support individuals' communication needs, as well as their behavior needs through the coordination of communication and behavioral supports.* <u>Medical and Nursing Supports</u> At the time of the review, both of the DDD community Nurse Specialist positions had been filled. Reports from State staff as well as the community provider staff the Independent Expert Team interviewed were positive with regard to the accessibility of clinical support, as well as information and technical assistance the Nurse Specialists were providing to the community nurses. As stated in the past, the Mortality Review Committee reports included recommendations for changes to community providers' practices and protocols for nursing intervention, which were consistent with the Independent Expert Team's findings. Based on brief interviews and review of records, it appeared the State was making good progress in addressing the need to improve nursing intervention practices. On a very positive note, during visits to community providers, examples of significant assistance and information the Nurse Specialists had given to provider nurses were evident. Protocols and Care Plan templates were identified as some of the documents provided to community provider agencies. During interviews, State staff reported greater openness on the part of community providers to accept technical assistance. Sometimes, technical assistance was offered following survey and certification reviews in which problems were identified. The State staff described one example of a provider that was placed on probation due to issues noted, some of which related to nursing care. Over time, this provider realized the benefit of accepting technical assistance, and State staff reported that this provider's nurses now sometimes proactively reached out to the Nurse Specialists for assistance. Documents suggested that the State continued to use the High Risk screening tool with a Prioritization Matrix to identify individuals at high risk. The Nurse Specialists used this list to prioritize individuals and evaluate their supports. The State continued to make efforts to disseminate to the community providers

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		information related to the acuity of individuals' needs based on the results of the risk screening tools. Through continued coordination with existing providers as well as discussion with new providers with strong clinical systems and experience working with individuals with more complex healthcare needs, the State continued to work towards strengthening and expanding capacity for the individuals the Settlement Agreement covers. The State reported continued work with existing MSU/ICF providers in strengthening existing healthcare supports for individuals they supported, as well as continued efforts to identify additional providers (some from out of state). As noted in the Independent Expert Team's three previous reports, the State had developed a curriculum for use at the Bridges program entitled "Supporting the health and well-being of the person with IDD." The curriculum covered general approaches to identifying and responding to individuals' medical conditions and medical emergencies, but also went into some depth with regard to specific and commonly encountered medical conditions for individuals with intellectual disabilities. The training included a testing component. At the time of the last review, the State had offered the training to community providers. Based on information the State provided, the training was offered in Omaha and North Platte in March 2013, and in Lincoln and Grand Island in April 2013. A total of 265 staff participated in the training sessions. These sessions were designed to be train-the-trainer sessions. It was anticipated that the participants would take the training back to their provider agencies to train more staff. In addition to encouraging the community provider staff to utilize the training materials, the State also had made the videos from the Bridges training available to the providers. This curriculum was a valuable resource, and it was positive that the State had offered it to community providers. At the time of the Independent Expert Team's 2014 review, plans were underway to hold a conference entitled: "It's My Life." The three-day agenda for the conference showed a variety of sessions, including some a clinical tract as well as a behavioral tract. This was another example of the State's efforts to expand community capacity with regard to clinical competency, including nursing competencies. In sum, with regard to nursing supports, during this review period, the Monitoring Team noted significant improvement of the nursing care in some community agencies, while inadequacies persisted in others. The Morality Review Committee reports continued to cite issues related to the availability of knowledgeable nurses and good nursing practice as well. However, the State had engaged in a number of efforts to ensure adequate supports and protections were in place, including the Nurse Specialists' review of individuals' nursing and medical supports, as well as CCS and survey and certification monitoring activities. In addition, the technical assistance activities of the Nurse Specialists were assisting the State in it efforts to improve community providers' capacity to provide appropriate nursing care and treatment to individuals with a variety of healthcare needs. Of note, the dental clinic at BSDC could accept referrals from the community. During the May 2014 review during a visit to BSDC, members of the Independent Expert Team briefly spoke with the BSDC Dentist and

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		hygienist. They confirmed that some individuals residing in the community continued to access the BSDC dental clinic. Generally, these individuals had not been able to access dental services in the community to meet their specialized needs. For example, some individuals required more time to acclimate to the dental office. The staff in the BSDC Dental Office had years of experience in working with individuals with intellectual and developmental disabilities, so it was positive that this option was available to individuals that were having difficulty accessing community dental services. <u>Physical and Nutritional Supports</u> The State was taking effective steps to expand the capacity of community providers and clinicians' (i.e., OT, PT, SLP and RD) expertise with regard to physical and nutritional supports through the planning and provision of PNS community-based training and clinical instruction. The provision of statewide PNS training should enhance community providers and clinicians' knowledgebase to better support individuals living in the community and/or individuals preparing to transition to the community. The Independent Expert Team reviewed a Community Services Education Proposal the BSDC Director of Physical and Nutritional Supports had developed. The content and planning for the future implementation of this proposal was impressive. The implementation of the courses presented in this proposal should assist community providers and clinicians to understand the positive impact that the development and implementation of individual-specific physical and nutritional support plans play in providing a foundation for an individual's health and wellness. The goal of the proposal was to "provide educational training for community providers and therapists to enhance dining, nutrition, positioning, and swallowing safety and support for individuals with intellectual and developmental disabilities (IDD)." The targeted audience would be caregivers, QIDPs, nurses and community therapists who provided services to individuals with IDD in the communities of Nebraska. The following objectives were identified to teach community providers and therapists: ▪ How to recognize warning signs of increased potential for choking and aspiration, and swallowing concerns; ▪ The value of good positioning at meals, during medication administration, and in alternate positions; ▪ Alternative and therapeutic positioning to help with constipation, breathing, movement, and posture; ▪ A better understanding of the nutritional needs of individuals with IDD; ▪ How to prepare easy, nutritious meals with accurate texture modifications; ▪ Signs and symptoms indicating a change in an individual's status; and ▪ How to identify the need for therapist to evaluate and develop programs to support an individual. The proposal discussed basic and advanced level courses. Basic level courses were designed for caregivers, day services personnel, family members, and other providers to build interest in topics related to physical and nutritional supports. Three basic level courses were identified:

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		▪ *Safe, Easy, Successful Meals!* (duration of three hours): o The content of this course covered the topics of how and what foods can be pureed and which should be avoided; thickened liquids and thickening agents; dining strategies safety supports; monitoring for signs of distress or risk; positioning considerations to enhance swallowing success; menu planning and substitutions to offer; demonstrations of food preparation, food samples, demonstrations of thickening liquids, preparing diet textures; and nutritional challenges in the IDD population. The course also defined the roles of a speech language pathologist and registered dietician, and would present a checklist of considerations to ask these clinicians when requesting services and supports. ▪ *In a Position to Help: Proper Positioning Improves Health, Safely, and Opportunities in Life* (duration of three hours): o This course presented the values of symmetrical positioning at meals, during medication administration and bedtime; the use of therapeutic positioning devices to improve range of motion, constipation, skin breakdown, and postural deformities; and wheelchair supports and other means of bolstering the body. The roles of the occupational therapist and physical therapist in therapeutic positioning would be discussed, and a checklist of considerations would be discussed to address when requesting services and supports from OTs and PTs. ▪ *On My Behalf: Communicating Client's Needs and Changes to the Primary Care Physician (PCP)*: o The subject matter of this course was designed to teach providers how to observe and record potential changes in individual's status by identifying individual-specific signs of wellness and/or illness. Obstacles to habilitative progress might include communication, range of motion, adaptive equipment, and environmental functionality. The impact of obstacles on wellness would be discussed which might include weight, lipids, blood glucose, and blood pressure management. The impact that gait, balance, and posture might affect positioning and falls. Safe food and liquid textures and proper pacing of meals can help prevent pneumonia in individuals with dysphagia. This course was to provide information on knowing when to request therapy support and evaluation, which might identify supports to facilitate learning and skill acquisition. In addition, this course was designed to support caregivers in identifying the unique ways in which individuals communicate changes that might indicate problems that should be reported to medical providers. Advanced level courses were designed for community therapists, such as speech language pathologists, dieticians, physical therapists, and occupational therapists to increase knowledge and build proficiency in supporting individuals with IDD. These included: ▪ *Basics of Dysphasia for Clients with IDD* (duration of four hours): o This course was designed to provide an overview of the dysphagia types and the swallowing problems commonly seen in individuals with IDD. Signs and symptoms of increased potential for choking aspiration would be described and demonstrated. The

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		need for various liquid and food consistencies would be reviewed, along with suggestions for teaching and monitoring appropriate textures. Techniques such as pacing, and the use of adaptive equipment, would be discussed. The use of enteral feeding versus modified diet with strategies and supports for safety would be reviewed from an outcomes and life quality standpoint. Oral motor therapy and other approaches would be considered in this discussion. Saliva management and oral care to reduce pneumonia would be discussed. The target audience for this course was to be speech language pathologists and registered dieticians. Nurses might also be interested, particularly those who work in MSUs. ▪ *Nutritional Care of the Adult with IDD* (duration of four hours): ○ This course was designed for registered dieticians in the community who provide nutritional services to adults with IDD. Nutritional assessment and body composition would be reviewed with discussion about the limitations of traditional body composition and weight measure. Practical approaches and best practice standards for nutritional assessment of adults with IDD would be provided. Menu planning, client food preferences, and weight management would be approached in an interactive discussion. Attendees would learn what to focus upon mealtime monitoring, and how to educate staff to properly prepare modified diet textures and thickened liquids. The use of enteral feeding versus modified diets would be reviewed from an outcomes and quality of life standpoint. An agency contracted with the State was coordinating the provision of statewide basic and advanced PNS courses. Beginning on May 2, 2014, the first of these courses, *Nutritional Assessment and Meal Planning for Individuals with Disabilities*, was scheduled for five different locations across Nebraska. The BSDC Director of Physical and Nutritional Supports and a BSDC Dietician were to present the training. This training was targeted for caregivers, provider staff, nurses, dieticians, dietary aids, quality assurance, and supervisory staff. Based on interviews with staff from the contracted agency, this was the first phase of PNS training to be provided in the community. Additional phases of training were being planned. Additional PNS training was scheduled for the *It's My Life* Conference, scheduled for September 2014. A PNS Clinical Services Consultant and the BSDC Director of Physical and Nutritional Supports were to present this course. The targeted audience was individuals with intellectual and developmental disabilities, their parents or guardians, service providers, community professionals and state staff. This training session was to introduce the basic principles of physical and nutritional supports to include basic definitions, signs and symptoms, preventative and reactive processes, and evaluations relevant to the overall implementation of an individual's comprehensive care plan. The development and implementation of the Community Services Education Proposal and the coordination of the provision of these courses for targeted audiences as described above should move the State forward in expanding the capacity of community providers and clinicians in their knowledge of PNS

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		and implementation of appropriate PNS plans for individuals. Community providers and CCSs continued to express their concerns with securing therapy services, especially as it related to securing SLPs to provide functional communication services and supports. In multiple interviews, community staff and CCSs had received therapy assessments that did not recommend the need for any therapy interventions. Details are discussed in further detail below. This was a significant problem for individuals with communication deficits as well as individuals at risk during daily activities. The planned training was a good start, but additional work will need to be done to expand the capacity of community clinicians, and to enhance their understanding of the need for the importance of providing communication supports, as well as comprehensive PNS services and supports to individuals. **Vocational and Day Services** *Areas Requiring Focused Effort* ▪ *Expansion was needed of options to meet this group's individualized needs and preferences, including additional opportunities for competitive vocational and integrated vocational/day activities.* With regard to expanding opportunities for employment and integrated activities for individuals supported in the community system, since 2007, the State had taken undertaken a number of important initiatives, and outcomes for individuals across the system appeared to be improving. Based on information the State provided: ▪ "With the approval of the two adult waivers in 2011, employment services were revised to provide greater opportunities for individuals to explore integrated employment... providers are able to bill for more time spent on assisting individuals with seeking employment. Employment services are compensated at enhanced rates to encourage providers to provide these services." ▪ Other steps the State had taken included, but were not limited to: in 2010, planning sessions were held to develop plans designed to achieve the goal of doubling the employment rate of people with developmental disabilities in the next five years; in conjunction with the Developmental Disabilities Planning Council, the Arc of Nebraska developed a transition tool-kit that included a series of three videos recorded by the Division of Developmental Disabilities; the Division also assisted another DD Planning Council grantee [to] develop the Ready-Set-Go transition planning guide; and the same grantee also developed an online training program called Together we Can, geared towards non-specialized providers and offered a module on job coaching. In terms of improved outcomes for individuals across the system, the State reported that based on a survey of Community Coordinator Specialists (CCSs): ▪ The number of individuals who were employed in an integrated setting increased from 18% to 23%. In 2013, 5% were working 20 or more hours per week, compared to 3% in 2007. ▪ The number of individuals who were volunteering in an integrated setting increased from 10% to 23%. ▪ The number of individuals who were participating in recreational activities in an integrated

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		setting increased from 40% to 64%. ▪ For individuals the Settlement Agreement covers, as of April 2014, 17 (14%) were accessing employment services funding (i.e., competitive and/or supported, including two of these individuals working independently without staff support), and 107 (86%) had funding for community inclusion, volunteer, or day activities. These data indicated incremental progress in each of the areas cited, suggesting that the State's efforts had been yielding positive results. In each case, there was also room for further improvement, reinforcing the need to continue those efforts and to continue tracking progress. IPPs were generally quite weak with respect to identifying meaningful, measurable goals related to employment. For example: The work-related IPP goal for Individual #419 was to "follow work expectations per work shift." While there was a paragraph generally describing the "vocational program," the specific skills that were the focus of the program were unclear, and it was not apparent how his performance would be assessed to determine progress toward the goal. While some individuals visited during this review were observed to have a range of vocational/employment options (including some with a measure of community integration), others did not appear to be actively moving toward participation in more integrated employment. For example, Individual #341 continued to attend a "pre-voc workshop." Provider staff indicated that if he could go a whole year with zero elopement attempts, he would be allowed to go to the "vocational planning" phase of the program. Staff reported that the CCSs for individuals preparing for transition to a community provider met with individuals and their guardians to discuss options for employment and day activities. However, documentation of this activity was inconsistent. Review of the Transition Plans for individuals visited during this community review yielded the following examples: • The Transition Summary for Individual #232 included documentation of a meeting on 11/30/12 at which "[provider staff] spoke about the amazing amount of employment options in Fremont." On 5/31/13, the individual moved to a home supported by this provider. His current IPP indicated that he had "a job distributing [flyers and papers]" and was "working during the day to obtain additional employment and exploring interests in different jobs." • The Transition Plan for Individual #419 indicated that the step: "Assess workshop vs. supported employment options" was completed on 1/6/14. The description stated: "[Individual] is very interested in obtaining paid employment… enjoys working outside, such as gardening… volunteered several months at [business] doing light maintenance and yard work… The [provider] Lincoln vocational site is very similar to the [provider] Grand Island site, so this will help with [Individual's] transition." The current IPP indicated that the individual generally worked on the farm "because I can earn money and I enjoy working on the farm."

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		• The Transition Plan for Individual #132 included no documentation that any steps related to "Day Programming, Vocational, and Employment Supports" had occurred, merely indicating that they "will happen prior to [Individual] moving and finding a willing provider." Her current IPP indicated that she volunteered at the Humane Society weekly and had been "looking for community employment." In sum, while the State's efforts to expand options for meeting individuals' needs and preferences, including additional opportunities for competitive vocational and integrated vocational/day activities clearly had paid off in terms of improved services and opportunities for some individuals, much work remained to ensure that all individuals are provided the opportunity for such benefit, and individuals and their guardians are offered options that allow them to make informed choices.
B44	Based on data and information gleaned, in part, from the State's Outreach Treatment Services ("OTS") and Intensive Treatment Services ("ITS") programs, the State shall develop and implement a plan with effective steps to expand and improve expert health care and expert psychological, behavioral, and mental health services in the community for community residents with complex health care needs, and/or behavior problems and/or mental illness. The intent of the plan shall be to better meet residents' health care, behavioral, and mental health needs in the community, avoid crises marked by the escalation of health care and/or behavior problems, and to minimize or eliminate failed or troubled community placements due to poorly addressed resident behaviors and, thus, minimize or eliminate re-institutionalization.	**Behavioral/Psychological Services** *Areas in which Less Oversight is Necessary* ▪ *As noted with regard to Section B43, the State had continued to contract with a behavioral services outreach provider, which had reportedly expanded its network of providers in the western part of the state. It generally appeared that they were providing valuable input that was beneficial to individuals and community providers.* *Areas Requiring Focused Effort* ▪ *Although improvements had been seen, one of the challenges that remained was ensuring that individuals that presented a need of external consultation or outreach services were referred. A process for behavioral risk screening or other method to identify individuals at increased behavioral risk in the community should be developed.* In various interviews, the Independent Expert Team was told how the State had developed and planned various training modalities to increase provider capacity and competence. BSDC psychologists had been training community providers on how to better complete functional assessments and behavior plans. The BSDC psychiatrists had continued to consult with psychiatrists in the community. DDD's conference entitled "It's My Life" was planned for September 2014, with nationally recognized experts scheduled to present on a variety of topics. With support from DDD, one of the State's contractors had been setting up trainings on various topics, including behavioral health topics, as well as some new training on physical and nutritional supports. A statewide conference on mental health issues also was planned through the Department of Mental Health. As noted in the Independent Monitoring Team's 2013 report: "In the 'Technical Assistance' section of the 'updates on significant activities' notebook provided by the State at the time of the tour, the State indicated: • 'In 2012, [Team Behavioral Consultation] services were evaluated and it was determined that

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		staff training and technology concerns are potential barriers to TBC service implementation… TBC services will be expanded in 2013-14 to provide for additional community training resources to enhance those currently available… In addition, the contractor suggested that the impact of TBC services could be enhanced by an earlier referral. Technical Assistance is proactively reviewing Therap GERs on a bi-monthly basis to identify individuals experiencing a high number or increasing number of behavioral related incidents during the period. Technical Assistance contacts the CCS or SC working with the individual to inquire whether the team has discussed the possibility of a TBC referral for the individual.'" The ITMS provider's annual report indicated that the agency had begun providing "additional community training resources" in the form of community-based workshops on the following topics: ▪ Self-care and boundaries for staff; ▪ Serving individuals with co-occurring intellectual/developmental disabilities and mental illness; and ▪ Conducting serious incident investigations. Staff reported that State Office personnel had been reviewing individuals' General Event Reports (GERs) and recommending that providers pursue the Team Behavioral Consult process when such consultation was indicated. There was also subsequent follow-up with providers to determine whether a TBC request had been initiated. Thus, it appeared that the planned further-development of TBC/ITMS services had occurred, yielding positive initial impressions of the impact of the changes. The provider administering the TBC service indicated that there were now six TBC teams operating in the state, three in Omaha, two in Lincoln, and one in Kearney. According to the provider's report, from December of 2013 through December 3013, TBC services were provided to 93 individuals. In 2013, the provider instituted fidelity checks regarding the implementation of TBC recommendations. The provider's annual report listed a number of barriers limiting the success of Team Behavioral Consultation, including: ▪ Agencies allowing limited time for staff training; ▪ Agencies not paying staff to complete competency assessments outside of work hours; ▪ Inadequate technology for communication; ▪ Delays in staff training; ▪ Lack of agency staff participation and follow-through; ▪ Agency middle management covering for direct support staff due to open positions; ▪ Direct support staff members' limited knowledge of basic behavior modification interventions; ▪ Discrepancies between staff reports and direct observation with respect to behavior description and frequency, habilitation programing, and behavior support plan implementation; and ▪ Agencies having a lack of easy access to support services (e.g., OT, PT, speech therapy, health care

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		providers, mental health professionals). Some individuals visited during this review had benefited from TBC services. For example: ▪ Individual #77 had received a Team Behavior Consultation in 2011. However, at that time, a different provider supported her. ▪ Individual #341 had received a Team Behavior Consultation during the period of May to September 2013. Provider staff reported that, by the time the consult occurred, the challenging behavior that had led to the request had diminished. However, the TBC report included many recommendations that were not directly reflected in his current BSP. ▪ Individual #286 had received a Team Behavior Consultation during the period of January to April 2013 in response to a report of increased "aggression… toward himself." The BSP in effect for the remainder of 2013 was not provided for review so it was not possible to determine whether the results of the TBC were incorporated into the plan. However, his IPP included the statement that "As a result of the… ITMS team working with me… I have had significant decreases in my SIBs [self-injurious behaviors]." It was encouraging to find more examples of utilization of TBC services during this review, compared to previous reviews. The TBC process shows promise for continuing to address situations that have the potential to disrupt individuals' placement in the community and for supporting providers in upgrading their behavioral assessment and treatment services. **Psychiatric Services** *Areas in which Less Oversight is Necessary* *The State had made efforts to reach out to community psychiatrists to offer technical assistance.* **Healthcare (i.e., Medical, Nursing, and Physical and Nutritional Management)** *Areas in which Less Oversight is Necessary* ▪ *DDD had engaged in initiatives designed to "expand and improve expert health care" including: completion of health risk and physical and nutritional management screenings, continued community outreach supports through use of DDD and BSDC's clinical teams, and use of the BSDC clinic to provide technical assistance, training, and primary care, when necessary. For example:* ○ *Using information from the health screening process that had been completed for all individuals the Settlement Agreement covered, the State had developed a prioritization matrix. Reportedly, the State's designated clinical team had seen all individuals covered by the Settlement Agreement currently living in nursing homes, as well as everyone with three high-risk designations on the health risk screening tools, as well as some individuals with two high-risk designations and one medium designation. Reports were generated with recommendations for additional supports and care to assist agencies that, at times, were struggling with the management of significant complex care issues. Concerns related to ensuring follow-up on these recommendations are discussed below. In certain situations,*

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		DDD staff made repeated visits, created care plans and protocols, and reached out to community practitioners to help facilitate care and develop policies, procedures, and protocols to support the development of the provider's system. ○ *DDD also was making efforts to reach out to the medical providers that supported individuals in the community. A list had been developed of the primary care practitioners (PCPs) for all of the individuals in the community that had resided at BSDC as of October 19, 2007. It was anticipated that some of DDD's clinical staff would set up meetings to build a rapport and identify themselves as being available for technical assistance. During such meetings, requests would be made for the names of specialists working with the individuals, in order for further outreach to be conducted.* ▪ *Two community Physical Therapists were working on a contractual basis at BSDC to work with individuals' teams, the Physical Nutritional Consultation Services team, and the consultant PT.* *Areas Requiring Focused Effort* ▪ *A system was needed to ensure that community providers and practitioners followed up on or provided justification for not following up on recommendations the DDD and BSDC clinical team made.* ▪ *A community nurse position had been created at State Office. Once it is filled, it should be helpful in providing needed training and technical assistance to Service Coordinators and DDD surveyors. However, concerns continued to be identified with regard to the quality of nursing oversight and activities in community programs, as well as in community providers' ability to assist individuals in coordinating healthcare services. It was not clear to the Monitoring Team that any technical assistance or training activities had been specifically targeted to address these issues.* ▪ *Physical and nutritional management supports varied widely in the community, and often were inadequate. DDD had and continued to attempt to identify a community resource for the development of a community-based physical and nutritional support team. However, efforts thus far had not resulted in the development of such a team/resource.* System to Follow-up on Recommendations from State Team As explained in previous reports, a Medical Review Team, consisting of the Chief Medical Officer of the State of Nebraska's Division of Developmental Disabilities and a nurse, had consulted with the teams of approximately 77 individuals in the community, and implemented a follow-up system to address recommendations resulting from the reviews. Since the last review, the State was using a slightly revised process. The two community Nurse Specialists were conducting reviews, using a standard template. The template developed was comprehensive and appropriate to the setting. At the time of the Independent Expert Team's most recent onsite review in May 2014, Nurse Specialists had completed reviews of approximately half of the 123 individuals living in the community, and covered by the Settlement Agreement. To prioritize these visits, the nurses reviewed the risk screen scores (i.e., Health Risk, Spine and Gait, and Physical and Nutritional Management Risk), as

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		well as data related to hospitalizations, medication errors, etc. The process for the reviews included review of any previous review the Medical Review Team had conducted to determine the status of recommendations from those reviews, review of current records, and an onsite review to interview staff, and observe the individual. A report was then generated for each individual, including findings related to medical, nursing and clinical care, as well as recommendations. The Chief Medical Officer reviewed all of the reports prior to their finalization. The reports were sent to the individuals' teams. According to the Nurse Specialists, they provided clarifications to the reports, if they were requested. In addition, after approximately 90 days, they followed up to determine if the team had any questions. Sometimes, the nurses' follow-up was in the form of an email, and sometimes, it was in the form of a meeting, depending on the number of recommendations, and the potential need for technical assistance. At times, guardians did not allow further follow-up. The CCSs were assisting in documenting community providers' and medical/therapy practitioners' follow-up to the recommendations. As discussed above with regard to Section B43, sometimes these reviews resulted in the provision of technical assistance to community provider nurses or other staff. A grid continued to be used to track the status and/or completion of each recommendation in medical case reviews. In addition, CCS narratives provided updates on recommendations. For the sample that the nurse on the Independent Expert Team reviewed, the Nurse Specialists had completed visits for Individual #169, Individual #200, Individual #111, and Individual #254. These reports were very comprehensive and individualized to meet each individual's specific health needs. The Independent Expert Team's interviews with individuals' community providers and CCSs confirmed the tracking and implementation of Nurse Specialist's recommendations, and/or justification if recommendations were not followed. Overall, the Nurse Specialist review process had resulted in the identification of valuable recommendations to which many teams and community practitioners were responding. In addition to providing a quality check on the healthcare supports provided to individuals, it also had opened the door to expand the community capacity for providing healthcare to individuals with complex medical needs. The process had resulted in the DDD Nurse Specialist developing relationships with community provider nurses, and sharing resources with them. The DDD Nurse Specialists consulting with community nurses and other practitioners had moved beyond the initial implementation phase, and was not only impacting the quality of care and improving outcomes for individuals, but also was opening the door for further collaboration and expansion of the knowledge of community nurses and other practitioners. The process for individual reviews and follow-up was well established, and State staff indicated that the expectation was that all individuals living in the community that the Settlement Agreement covers would have a review conducted in 2014. As noted in the report for the January 2013 review, it is recommended that

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		this become an area requiring less oversight. Development of Community PNCS Team As stated in a previous report, a State report (i.e., Meeting Health Support Needs of People with IDD in Nebraska Community: New Initiatives and Future Directions) indicated that multiple Medical Team reviews identified individuals for whom recommendations were made for specialized, integrated physical and nutritional support services. This report highlighted the need for expanded physical and nutritional supports and services (i.e., community-based Physical and Nutritional Consultative Support Teams) for individuals residing in the community. However, at the time of the review, there was no functioning community-based PNS team. Although the report recognized capacity in the community was limited, it offered some ideas to address this issue, such as use of tele-health, expansion of the use of clinics that have some of these resources, and "enhanced inter-professions communications through shared goals, reviewing progress, and adapting universal forms such as point-of-service forms, which capture goals, outcomes, implementation of action plans, responsibilities, and others." At the time of this most recent review, there was no community-based PNCS team. However, there were several individuals and their staff (i.e., Individual #109, Individual #111, Individual #200, Individual #33, and Individual #254) who would have benefited from a PNCS team's consultation. More specifically: ▪ A community provider had been working diligently with Individual #109. Individual #109 had been hospitalized multiple times with a diagnosis of aspiration pneumonia. Based on report, Individual #109 was hospitalized again during the week of the Independent Expert Team's onsite review, and after the Independent Expert Team's onsite visit. The DD Program Specialist RN completed a report, dated 4/3/14, after a visit to Individual #109's home on 3/28/14. The Chief Medical Officer made the following recommendation in a previous Medical Review report: "seek the advice of an interdisciplinary physical and nutritional support team that would coordinate [Individual #190's] physical and nutritional needs." During the onsite review, the BSDC PNCS Director suggested his team might want to consider suction tooth brushing. Individual #109 and his community provider would benefit from consultation with a PNS team. ▪ Individual #33 resided in a nursing facility. Individual #33's Community Coordination Specialist reported during the onsite review that Individual #33 was "steadily declining." She had multiple health concerns and did not have a comprehensive PNS plan to minimize and/or reduce her health risk factors. She would benefit from a comprehensive PNS team assessment. ▪ Individual #200 PNS and Health Risk screen scores were high. Individual #200's Medical Review report, dated 4/23/14, recommended consultation with an occupational therapist and/or speech pathologist to complete an elevation assessment. A previous Medical Review, dated 8/30/12, recommended: "consult with an interdisciplinary physical and nutritional support team in order to obtain a comprehensive and integrated physical and nutritional support program." The Independent Expert Team observed Individual #200's staff standing to present his medications. His head and neck were in hyperextension, which placed him at risk. Individual #200 did not have a comprehensive physical and nutritional support plan to provide staff with written and

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		photographic instructions to minimize his identified high PNS risks. His DDD medical review, dated 4/23/14, made the following recommendations related to physical and nutritional supports: ○ Multiple recommendations to his primary care physician (i.e., obtain full set of labs considering dietary consult and changes); ○ Consultation with occupational/speech therapy about elevation of head of bed and Individual #200's degree of positioning while in his recliner; ○ Competency-based training on Individual #200's nutritional recommendations made by the registered dietician; ○ Safety plan said to have Individual #200 remain upright 45 minutes to an hour and Health Support Plan said 30 to 45 minutes. Consistency across plans was recommended; ○ Confirmation of thickness of liquids, because pudding thick and honey thick were both used; and ○ A follow-up speech evaluation regarding communication and specifically documentation of results of breathing assessment. Individual #200 and his team would benefit from a comprehensive PNS team assessment. ▪ Individual #254's PNS and Health Risk screen scores were high. During an interview with the community provider in regards to this individual's high-risk PNS concerns, the nurse and other staff stated the individual had gained weight, although the records submitted indicated the individual had been losing weight and was outside his ideal body weight range. Guidelines of Care had been developed and implemented for this individual, but this plan was not readily available for staff use. The plans did not identify individual-specific triggers to alert staff to a potential change in status. The nurse was not aware of the correct position for this individual in sidelying or the reason it was prescribed. In addition, it was of concern that the primary intervention established for individuals with a "possible bowel obstruction" was to call 911. Nursing staff should develop and implement a nursing care plan that identifies triggers to alert staff to a potential change in status for this individual and define when staff should contact the nurse for assistance. Nursing staff also should also implement nursing protocols that minimize this individual's risk for future "possible bowel obstruction." These individual-specific examples highlight the ongoing need for a community-based PNCS team. The Independent Expert Team continues to offer the following recommendations for the State's consideration to expand the provision of physical and nutritional supports: ▪ Addition of fact sheets on the State's website that provide a general overview on topics important to supporting an individual's health and safety and improving their quality of life. Some examples would include: recognizing signs and symptoms of aspiration pneumonia, therapeutic positioning, aspiration prevention and dysphagia, best practices in enteral nutrition, recognizing changes in status, development of POS plans, examples of POS plans, development of dining plans, and examples of dining plans;

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		▪ Development and implementation of an annual conference for community clinicians in collaboration with state colleges/universities to provide clinical instruction on current trends in the provision of supports to individuals with intellectual and developmental disabilities; ▪ Review of general event records to identify health care risk trends and develop strategies to minimize the risks (i.e., hospitalizations for individuals with a discharge diagnosis of aspiration pneumonia); ▪ Development of a statewide network with higher education institutions to recruit and build capacity for community therapy resources (i.e., OTs, PTs, SLPs, and RDs); and ▪ Development of a comprehensive list of regional and statewide clinical resources and the services provided to be published and distributed to individuals, guardians, and community providers. Most importantly, the State, community providers, and other stakeholders should continue to collaborate in the development of a model and identification of a funding source(s) for a coordinated/integrated sustainable system for providing physical and nutritional services and supports. <u>Community Nurse Positions</u> As noted in the previous report, DDD had created and filled two community Nurse Specialist positions. At the time of the most recent review in May 2014, both of these positions have been filled, and the nurses were actively engaging the provider community in sharing their knowledge and expertise to enhance the quality of life for the persons residing there. Based on the Independent Expert Team's most recent review, the knowledge and skill these staff brought to the table were welcome additions, and CCSs and surveyors were seeking and using their expertise. The State's Nurse Specialist positions provided a resource to assist CCSs and providers in defining and implementing systems and structures to provide consistent and thorough healthcare oversight. One of the ways this was accomplished was through nurse-to-nurse education on healthcare plans, protocols and monitoring tools, including technical assistance to ensure an understanding of the importance of and use of the tools. In previous reports, the Independent Expert Team identified a number of healthcare issues for which resources and/or technical assistance would be helpful to improve the services provided to individuals. During this review, examples (e.g., aspiration prevention during eating for Individual #200) of specific technical assistance that the State Nurse Specialists provided to the community agency nurses were noted. In addition, the State is encouraged to continue to use their clinical resources to enhance the healthcare sections of the IPP, transition plans, and CCS Monitoring Tools. Given that individuals' IPPs are the guiding documents on which much monitoring is based, it is essential that improvements be made in their definition of healthcare supports individuals require, including nursing supports. If the IPPs include clear descriptions of the supports individuals require, then CCSs and surveyors have a roadmap to consistently monitor supports of those in the community. Continued utilization and expansion of the roles of the State Nurse Specialists will be invaluable in ensuring appropriate health supports are provided.
B45	To assist in this process, the State	*<u>Areas in which Less Oversight is Necessary</u>*

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	will develop and implement a plan on or before March 1, 2009, to utilize and/or expand the State's existing electronic information system/tele-health network to better meet the needs of persons with developmental disabilities, especially those living in more rural areas of the State. The plan shall address how to provide more immediate and better access to records and expert professionals, transmit lab results and radiological reports between health care and other professionals, better track quality of care, improve communication with local hospitals and specialists, and generally provide better proactive care and treatment through a more seamless continuum of care to enhance resident outcomes. The plan shall address how to conduct video-conferences among various health care providers at scattered locations to save time and the expense of travel, and to encourage, wherever appropriate, the use of video-consults/clinics between local physicians and other professionals with specialists at distant locations. The plan shall also address how to incorporate timely tele-trauma services for residents in crisis. In developing and implementing this plan, the State shall ensure that the security and privacy of resident information is safeguarded.	▪ *A tele-health network existed, and reportedly was continuing to be developed/expanded. State staff interviewed reported that it could be accessed at many local hospitals and the regional public health clinics. It was available at BSDC, and was used. For example, it was used for psychiatric as well as neurology consultation. Anecdotal use of it was described for individuals living in community settings. Although a specific plan, as the Settlement Agreement requires, was never presented to the Monitoring Team, such a plan does not seem necessary or relevant at this juncture. The system exists, and provides an option, when appropriate.* *Areas Requiring Focused Effort* ▪ *As the Chief Medical Officer and the State Office nurses are out reviewing supports and services, tele-health will be discussed and recommended as appropriate.* ▪ *Based on information the State provides, the Independent Expert provide estimates of the numbers of individuals the Settlement Agreement covers that are using tele-health.* The Independent Expert Team did not evaluate the State's status with this provision during this review.
B46	The State shall significantly expand	*The status of the OTS program is discussed above with regard to paragraph B44.*

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	its OTS program to address unmet needs in the community that place individuals at risk of short-term or long-term institutionalization at BSDC. The OTS program shall continue to support positive behavioral change to keep individuals as independent as possible, and in familiar surroundings in their homes in the community, and away from more restrictive placements such as hospitals, nursing homes, psychiatric facilities, and institutions.	
B47	The State shall continue to support its ITS program, but shall strengthen its focus on returning individuals back to appropriate community homes promptly after a short-term stay. The State shall maintain more restrictive criteria for admitting a person long-term to a congregate or institutional setting after a stay in the ITS.	*Areas in which Less Oversight is Necessary* ▪ *This is an area that no longer requires oversight. The Intensive Treatment Services Program no longer exists on the BSDC campus. Individuals were transitioned to other homes on campus or into the community. Based on information dated 3/29/12, six individuals had been newly admitted to BSDC since October 19, 2007, and another eight individuals returned from other placements. Two of these individuals returned to the community quickly.* ▪ *The State had contracted with a community provider to operate a small crisis stabilization/evaluation home to replace ITS. It had the capacity to support a maximum of four individuals at a time. Individuals who were placed there generally had short stays. For example, some individuals from Bridges or BSDC had stayed at the home for up to a few months at a time, and then transitioned to more permanent homes in the community. So far, the one home was meeting the need for this type of support. However, the State had discussed a back-up plan with the community provider should more capacity be needed.* *Areas Requiring Focused Effort* ▪ *Based on information from the State, the Independent Expert will include information about the numbers and lengths of stay of individuals who:* ○ *Require Emergency Room visits or hospitalizations for psychiatric or emotional crises; and* ○ *Utilize the small crisis stabilization/evaluation home.* ▪ *The Independent Expert will continue to look at the ways in which crises are avoided.* Numbers and Lengths of Stay for Psychiatric Hospitalizations This was not addressed in this review, but was addressed in the report for the review completed in January 2013.

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		Utilization and Lengths of Stay for Crisis Stabilization/Assessment Center This was not addressed in this review, but was addressed in the report for the review completed in January 2013. Avoiding and Addressing Crises This was not addressed in this review, but was addressed in the report for the review completed in January 2013.
Monitoring of Community Placements and Quality Assurance Measures		
B48	The State shall develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms shall serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight shall include regular inspections of community residential and program sites; regular face-to-face meetings with residents and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records.	*Section B48 requires development and implementation of "a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need." To assess this, the Monitoring Team historically has reviewed the protections, services and supports individuals are provided to determine if they meet their needs, as well as the State's system for monitoring. Section B23 also relates to the adequacy of the provision of protections, services and supports, when it states: "…the State shall actively pursue the appropriate discharge of BSDC residents from BSDC and provide them with adequate and appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated…" To address these requirements, the following includes information about the adequacy of protections, supports, and services, as well as the service coordination monitoring and incident management systems in place to monitor them. Section B49 also addresses service coordination. Section B53 addresses the State's review of community providers, which entails monitoring as well.* **Individual Program Plans (IPPs)** *Areas Requiring Focused Effort* ▪ *As the Monitoring Team's previous reports have indicated, appropriately, the IPP was a central document in 404 Regulations. It was the document in which an individual's protections, services, and supports were to be detailed. Relying on the IPP process was appropriate as one of the methodologies to hold providers accountable for the delivery of protections, supports and services, because it allowed individualization of the person's service array. However, this will require the State to ensure that IPPs clearly identify the full array of measurable protections, supports, and services individuals need. In conversations with the State staff, they recognized that the IPPs required improvements and were taking steps to address this issue. Two areas requiring focused efforts included:* ○ *Finalizing and implementing the revised IPP process with emphasis on ensuring that the IPPs identify the full array of protections, services, and supports the individual needs in measurable terms; are based on adequate assessments that are reflective of the individuals strengths, needs, and preferences; incorporate current data; provide for an adequate*

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		program of habilitation and skills training reflective of the individual's interests and needs; are developed by a duly constituted team; and are revised as appropriate; and ○ *Updating the audit process that Service Coordinator supervisory staff were using to ensure the quality of the IPPs to coincide with the revised IPP format and instructions. Given that rights restrictions noted in some IPPs were insufficiently specified, outdated, or unnecessary, and some reviews of restrictions did not constitute adequate protection of individuals' rights, this should be an area of focus with the audits.* As noted in the last report, State Office personnel indicated that a revised IPP process was being pilot tested, which was positive. Specific issues regarding IPPs reviewed during this review were detailed above with regard to Section B26. These remained areas requiring focused effort. **Medical and Nursing Care** *Areas in which Less Oversight is Necessary* ▪ *Documentation of the provision of basic medical care needs was often present, such as annual physical examinations. However, as discussed below, in some cases, follow-up care was neglected, pointing to failures in monitoring and clinical oversight.* *Areas Requiring Focused Effort* ▪ *With regard to the provision of medical and nursing care, although this varied from provider to provider, the Monitoring Team continued to identify concerns related to adequate: 1) ongoing nursing assessments of individuals with various risk factors; 2) nursing care plans with regular updates; 3) protocols or guidelines to assist direct support professionals in ensuring the health and safety of individuals; 4) ongoing-day-to-day monitoring/tracking of individuals' health care issues; 5) clinical oversight of the day-to-day health supports provided to individuals; 6) for individuals that required assistance, coordination to track routine and specialty healthcare appointments; collect adequate information about individuals' diagnoses, treatment, recommendations, and expected outcomes; ensure communication between medical providers; and ensure timely and complete follow-up to recommendations from medical providers; and 7) training as well as clinical support for direct support professionals to allow them to identify signs and symptoms of illness, and document, and communicate vital health information to healthcare providers. Providers generally did not have auditing or monitoring systems in place to assist in ensuring that individuals received adequate health care supports.* Review of available documents for Individual #33, Individual #109, Individual #344, Individual #254, Individual #200, Individual #169, Individual #285, and Individual #111 showed that for these individuals, overall medical consultation had occurred, such as annual examinations and routine preventative care. Enhancements to the CCS monitoring tools as well as training for the CCSs had strengthened the State's ability to pick up on the specialty health care needs of individuals and ensure their completion. This continued to show improvement from past reviews, when many times community providers had

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		overlooked the specialty healthcare needs of individuals. While some community provider agencies had minimal, if any, formal processes in place to ensure oversight of healthcare supports, others had documentation in the form of Nursing Care Plans, Medication Safety Plans, or Staff Objectives in place. Of significance is that five of the eight individuals visited (63%) were receiving nursing care based on their individualized needs. Several of these provider nurses noted that the State Nurse Specialists were a valuable resource. Clinical nursing support via phone triage, onsite assessment, or other means is necessary to ensure proper routine preventative and emergency care is facilitated. For the three individuals not receiving nursing services based on their individualized needs, the following problems were noted. If for these individuals a Nurse Specialist had conducted a review, discussion is provided of applicable components of the Nurse Specialist's report and recommendations: ▪ For Individual #200, day-to-day tracking of blood pressure readings had not been done for the month of May 2014 as ordered, even though in previous months it was being done. Staff were reportedly following dietary and medication administration appropriately since the DD Nurse Specialist had done observation and training on these several weeks prior. ▪ For Individual #254, the provider did not have a quality assurance system in place to ensure that the individual was receiving consistent, appropriate care for a 24-hour period, which is imperative given his level of health needs. The DD Nurse Specialist had not yet assessed this individual. ▪ For Individual #33, there was ongoing concern about whether this individual was receiving appropriate psychiatric care, including review of the number of psychotropic medications being prescribed given her age and health status. The DD Nurse Specialists had not visited this person. Additionally, as previously mentioned, based on review of documentation related to recommendations made by the State clinical as a result of medical staff's reviews of the individuals supported under the Settlement Agreement, follow-up action appeared to have occurred with review by State staff following initial reviews, and at times, subsequent visits to ensure processes were in place to manage care. It was observed during this review that the DD Nurse Specialists have provided excellent, appropriate education and technical assistance to the individuals and staff they have assessed and visited. The challenge is for only two nurses to be able to meet the needs of everyone needing these services. **Physical and Nutritional Supports** *Areas Requiring Focused Effort* ▪ *With regard to physical and nutritional support plans, although there was variability between providers, many individuals whose physical and nutritional management (PNM) and Spine and Gait screening tools showed them to be in the high and medium risk range had inadequate dining plans, and inadequate or no plans for medication administration, oral care, bathing/showering, personal care, wheelchair and alternate positioning, lifting and transfers, and/or communication.* ▪ *Often the underlying assessments were inadequate, and did not provide the basis for the development of adequate PNM plans and/or other therapy programs. They did not consistently*

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		incorporate the necessary assessment criteria, including: diagnoses and/or description of significant health care issues; health risk indicators; orthopedic concerns; musculoskeletal status; posture; functional mobility; functional performance of activities of daily living; communication; impact of health care issues on performance and therapeutic intervention; description of current therapeutic supports, which would include mealtime, positioning and alignment, and assistive technology; baseline measurements, where appropriate; and analysis of findings to provide a rationale for recommendations and intervention strategies. ▪ *It should be noted that as a result of largely missing plans, the Monitoring Team could not meaningfully assess whether staff had been adequately trained, or if adequate monitoring of the plans' implementation was occurring.* <u>Physical and Nutritional Support Plans</u> Community providers continued to develop and implement individual-specific protocols and/or procedures to provide direct support professionals with written instructions in providing supports for individuals during mealtimes, bathing, transfers, wheelchair and alternate positioning, medication administration, and oral care. However, some of these protocols were missing essential components such as photographs, or they contained inadequate instructions, or were not readily available to staff. As stated in multiple reports, individuals with a PNM high and/or medium risk screening ranking should have a PNS plan(s) that adequately and appropriately focuses on physical and nutritional support needs throughout the 24-hour day to minimize individual-specific risk factors. These plans should include written and photographic instructions to assist staff in implementing these plans. The plans should, at a minimum: ▪ Identify individuals' risk factors; ▪ Identify individual-specific triggers related to risk factors to alert staff to potential problems; ▪ Provide large, color photographs of prescribed adaptive equipment; ▪ Include wheelchair and alternate positioning instructions that identify safe elevation ranges in seating systems and alternate positions to minimize health risk factors (e.g., aspiration); ▪ Detail bathing/showering equipment and positioning instructions, including safe elevation range; ▪ Detail oral and dental care instructions, including equipment and position of individual/staff; ▪ Include personal care instructions, if an individual cannot lie flat due to risk factors [(e.g., aspiration, gastroesophageal reflux disease (GERD), etc.]; ▪ Include mealtime plans that describe individual-specific triggers, food texture, fluid consistency, mealtime equipment, positioning for the individual and staff, staff and individual presentation techniques, and the amount of time to remain upright after the meal; ▪ For medication administration, describe wheelchair and/or alternative positions with safe elevation range, adaptive equipment, and prescribed food/fluid consistency; ▪ Specify staff techniques for lifting, transfers, and mobility; ▪ Include a communication plan describing how the individual communicates and staff strategies for how to communicate with the individual. If the individual has an alternative and

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		augmentative communication (AAC) system, provide staff strategies to engage the individual with the AAC system; and ▪ Describe any additional individual-specific instructions required to meet the individual's PNM risks not addressed above. The Independent Expert Team requested copies of individuals' PNS plans (i.e., dining/mealtime plans, including diet texture and fluid consistency; oral hygiene/tooth brushing plans; bathing/showering plans; medication administration plans; personal care plans; wheelchair and alternate positioning plans; and transfer plans). The Independent Expert Team reviewed the plans and/or documentation submitted by community providers for eight individuals (i.e., Individual #109, Individual #344, Individual #111, Individual #169, Individual #200, Individual #33, Individual #254, and Individual #143). Individual #285 and Individual #65 had PNS risk screen scores of low, and did not require the development and implementation of a PNS plan. Individuals' plans reviewed had some of the necessary PNM plan components identified, but were missing other important components. More specifically: ▪ Individual #109 lived in a MSU with 24-hour supervision and nursing care. His PNS and health risk scores were high. o A Luna Track Lift/Hoist transfer procedure was provided. The Nursing Care Plan stated: "use 2 staff and gait belt or 2 staff and mechanical lift for transfers." A transfer plan should incorporate the Luna track lift/hoist transfer, gait belt, and mechanical lift instructions. The plan should include pictures of the adaptive equipment and the different transfers performed by staff. o His dining plan, dated 3/21/13, stated: "head elevated to a minimum of 30 degrees at all times." However, his dining plan did not identify the types of positions that were safe for receiving enteral nutrition and did not have pictures of the approved positions to receive enteral nutrition. The dining plan did not address if he was to remain upright after receiving enteral nutrition. o The Nursing Care Plan indicated: "use safety belt when in shower chair." He did not have a bathing plan developed for staff use. Such a plan should provide written instructions and provide a picture of his shower chair. o A Colostomy Pouch Emptying and Colostomy Pouch Flatus Release procedures were submitted, but did not identify the degree of elevation that should be maintained to minimize his risk of aspiration. There were no dates provided on these procedures. o An Instillation of Medication for Ear, Nose, and Eye procedure was submitted. The procedure did not provide the types of positions and/or the degree of elevation that should be maintained while providing medication to his ears, nose and/or eyes. o A Medication Administration via gastrostomy (G-tube) procedure was submitted. These procedures did not identify the degree of elevation that should be maintained to minimize his risk of aspiration. o The Nursing Care Plan stated: "[Individual #109] will have oral cares every 2 hours for 3 consecutive months." Staff were to assist and encourage him to brush his teeth with a

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		soft brush twice daily, assist him in brushing his tongue, and use antimicrobial mouthwash with assistance. However, the plan did not provide instructions to identify the degree of elevation that should be maintained to minimize his risk of aspiration. ○ Multiple communication strategies were included in the Nursing Care Plan, which was positive. ○ The Nursing Care Plan was nine pages in length. This plan would not be user-friendly for direct support professionals as a quick reference tool to assist in implementing strategies to minimize risk. For example, multiple instructions for wheelchair and/or alternate positioning were identified in multiple sections. The provider should consider the development of PNS plans that provide direct support professionals with written and pictorial instructions for wheelchair and alternate positioning, oral care, personal care, and bathing. These plans should include pictures of prescribed adaptive equipment (i.e., shower chair, mechanical lift, and pictures of the individual in the wheelchair, bed, positioning and/or other alternate position, such as the recliner). ▪ Individual #344 lived in a MSU with 24-hour supervision and nursing care. His PNS and health risk scores were high. ○ A Luna Track Lift/Hoist transfer procedure was provided. The Nursing Care Plan stated: "use 2 staff and gait belt or 2 staff and mechanical lift for transfers." A transfer plan should incorporate the Luna track lift/hoist transfer, gait belt, and mechanical lift instructions. The plan should include pictures of the adaptive equipment and the different transfers performed by staff. ○ His dining plan, dated 12/29/13, stated: "head elevated to a minimum of 30 degrees during feeding and for 30 minutes after feeding." However, his dining plan did not identify the types of positions that were safe for receiving enteral nutrition, and did not have pictures of the approved positions to receive enteral nutrition. The food dislikes section stated "NPO." The provider should consider stating that Individual #344 was to receive nothing by mouth, as opposed to using the abbreviation NPO. ○ On a positive note, the Nursing Care Plan provided multiple instructions for bathing such as: "use shower chair with towel over back when showering, have consistent staff bathe and care for [Individual #344], allow [Individual #344] to participate in cares as much as possible and provide praise for accomplishments, etc." ○ Alternate positioning in the Nursing Care Plan included: "use hospital bed with 2 side rails, staff will use proper positioning for [Individual #344] and use pillows when appropriate, sit in an armchair with armrests, ensure proper positioning with HOB greater than 30 degrees to decrease aspiration risk and enhance lung expansion." The provision of pictures for alternate positioning would have assisted staff in following the Nursing Care Plan for alternate positioning. ○ Wheelchair positioning instructions were included in the Nursing Care Plan, such as: "will wear a seat belt while in wheelchair, staff will put shoes on [Individual #44] when up in wheelchair, uncross legs when going through doorways, repositioning every 2

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		hours and as needed, will have time in wheelchair, etc." The provision of pictures for wheelchair positioning would have been helpful to staff. ○ Personal care instructions in the Nursing Care Plan stated: "check/change [Individual #344] every 2 hours and as needed, apply barrier cram to buttocks and reddened areas." However, the plan did not include a safe degree of elevation. ○ The Nursing Care Plan was 10 pages in length, which would make it difficult for direct support professionals to access information quickly. ▪ Individual #111 lived in a MSU. His PNS and health risk scores were high. ○ His dining plan included the following: individual triggers, food allergies, food dislikes and likes, diet, food texture, fluid consistency, adaptive eating equipment, positioning, and eating/drinking strategies. His dining plan's food texture was ground foods for breakfast and dinner and all other meals/snacks were to be pureed. The fluid consistency was thin liquids for breakfast and all other fluids were to be nectar consistency. It would have been helpful for the Speech Pathologist to provide a rationale for the different food textures and fluid consistencies to be presented at different times of the day. ○ A Protocol for Oral Care for Client with Aspiration Risk was submitted with Individual #111's information. This protocol was a competency checklist with 14 identified activities (e.g., ensure client is positioned upright prior to performing oral cares, moisten bristles of toothbrush, brush client's teeth and tongue, etc.). Important steps were identified to remind staff to provide oral care per schedule, ensure the individual was positioned upright prior to performing oral cares and monitor for signs and symptoms of aspiration. However, this protocol was not individualized for Individual #111. ○ A showering protocol was submitted that provided a House Competency Checklist with 25 steps to be followed by staff. However, this protocol was not individualized for Individual #111. ○ Bladder, bowel symptoms, and night check and change protocols were submitted. However, these protocols did not provide staff instructions for personal care, which should include level of independence, and level of staff assistance required. The degree of elevation should also be identified. ○ Wheelchair seating/positioning evaluation, dated 9/27/11, described his seating system and had two pictures (i.e., front and side-view in his wheelchair). However, there were no written instructions, including safe elevation ranges, frequency of repositioning, and any relevant individual-specific instructions. ○ Repositioning Protocol instructed staff to: "reposition client at least every 2 hours or as needed, perform ROM [range of motion] exercises and allow [Individual #111] to walk approximately 75 feet or length of hallway as tolerate with assistance each day." Additional instructions should be provided to staff to assist them in providing range of motion exercises. ○ On a positive note, an Easy Stand Protocol was submitted, which provided individual-

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		specific instructions for transferring and positioning him in the stander. ○ Stand/Pivot Client Transfer with a gait belt provided adequate written instructions with five steps to be followed. ▪ Individual #169's resided in a MSU. Her PNS, Spine and Gait, and Health Risk screen scores were high. ○ Individual #169's dining card included individual triggers, food allergies, food dislikes and likes, diet, food texture, fluid consistency, mealtime adaptive equipment, positioning, and eating/drinking strategies. This dining plan included appropriate components to assist staff during mealtimes. ○ A Protocol for Oral Care for Client with Aspiration Risk was submitted. This protocol was a competency checklist with 14 identified activities (e.g., ensure individual is positioned upright prior to performing oral cares, moisten bristles of toothbrush, brush individual's teeth and tongue, etc.). Important steps were identified to remind staff to provide oral care per schedule, ensure the individual was positioned upright prior to performing oral cares, and monitor for signs and symptoms of aspiration. However, this protocol was not individualized for Individual #169. ○ A showering protocol was submitted that provided a House Competency Checklist with 25 steps for staff to follow. However, this protocol was not individualized for Individual #169. ○ Provision of Medication via G-tube had 45 steps for staff to follow. However, this protocol was not individualized for Individual #169. ▪ Individual #200 resided in a community residential home. His PNS risk screen score was moderate and Health risk screen score was high. ○ Positioning Program for Individual #200 identified basic concepts and positioning options for wheelchair and alternate positioning (i.e., bed positioning for supine, sidelying, and prone). However, the positioning program did not provide instructions for safe elevation ranges in his wheelchair or alternate positions to minimize his risk of aspiration. ○ A document was submitted with six nursing diagnoses: risk for aspiration, constipation, impaired skin integrity, risk for injury, ineffective airway clearance and ineffective tissue perfusion. Each nursing diagnosis identified goals and outcome criteria, staff interventions/implementation, and evaluation of goals and outcome criteria. The sections for the evaluation of goals and outcomes criteria were blank for all six diagnoses. The staff intervention/implementation sections provided staff instructions for mealtimes within multiple diagnosis sections. However, this document would not be user-friendly for staff. Staff would have to look through the entire five-page document to identify relevant instructions for personal care, transfer, mealtime/snack, oral care, bathing, and medication administration. ▪ Individual #33 resided in a nursing facility and did not have an Individual Program Plan. On 11/19/13, the CCS completed the Health Risk, PNM Risk, and Spine and Gait screenings, but a

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		score was not identified on these documents. ○ The nursing facility provided a plan of care. Individual #33 received a "dysphagia level 1 texture" diet. This diagnosis placed her at risk for choking and aspiration. The plan of care was not adequate to provide staff instructions for wheelchair and alternate positioning, mealtimes/snacks, oral care, bathing, personal care and medication administration to minimize her risk of aspiration. For example, the plan of care stated: "provide daily oral cares." ▪ Individual #254 resided in a residential community home. His risk screen scores for Health, PNS, and Spine/Gait were high. ○ Dysphagia Procedures identified signs of dysphagia, signs of aspiration, Individual #254's mealtime position and safe elevation range during the meal, time to remain upright after the meal, mealtime adaptive equipment, and staff assistance techniques and precautions. However, these procedures did not provide pictorial instructions for staff. ○ G-Tube Assessments and Cares did provide staff instructions to "elevate client's head to 45 degrees or assist to a sitting position" for a safe elevation in the wheelchair. The procedures did instruct staff "to maintain elevated 45-90 degrees position for 30 minutes after feeding if possible." This was positive. ○ Medications Per G-Tube instructed staff "to correctly position the client. His head should be elevated at least 45 degrees or sitting upright which is 90 degrees." Staff were to "keep client in an upright position for 30 minutes." Again, this was positive. ○ Skin Care protocols provided instructions for showering and personal care. However, these instructions did not provide a safe elevation range during these activities. ○ Positioning instructions did not provide a safe elevation range for sidelying positioning, which occurred five days a week in the day program. There were no pictorial instructions of Individual #254 in his sidelyer. Bed positioning instructions did not provide a safe elevation range to minimize his risk of aspiration. ○ Wheelchair positioning instructions stated: "if he is in his W/C [wheelchair] for periods over 2 hours, he will also be repositioned by adjusting his tilt at the 2 hour mark." There were no pictures of Individual #254 in his wheelchair. ○ Oral Care procedures did not identify a safe elevation range for Individual #254 during oral care, or provide instructions for staff to be at eye level when brushing his teeth to minimize the risk of his head going into hyperextension, which had the potential to place him at risk of aspiration. As stated in the last report, the provision of comprehensive PNS plans for individuals in community-based settings continued to be an area that required focused effort. PNS plans should be readily accessible to staff as they support individuals throughout the 24-hour day. Community providers should develop and implement individual-specific PNS plans for individuals identified at high and/or medium risk for physical and nutritional concerns. These plans should provide techniques that span the 24-hour day, seven days a week to promote health, function, and comfort, as well as minimize the individual's physical and

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		nutritional risks. The content of these plans should be based on assessment results (i.e., OTs, PTs, SLPs, and Dieticians) and be supported by clinical justification. Professional staff responsible for the development, implementation, and/or oversight/monitoring of PNS plans (e.g., OTs, PTs, SLPs, Dieticians, Nurses, CCSs, and State Surveyors) should be provided with training that identifies the rationale for a PNS plan (i.e., to minimize identified risk indicators), content of discipline-specific assessments that provide justification for PNS plans, and the required components for the development of a comprehensive PNS plan. In summary, community providers were developing and implementing some components of PNS plans for individuals at high and/or medium risk, and this was a positive achievement. However, additional work was needed to ensure individuals at high and/or medium PNM risk were provided with comprehensive PNS plans that incorporated the necessary components. **Therapy Assessments (Occupational and Physical Therapy)** The Independent Expert Team requested individuals' OT and PT assessments, and any OT and PT consultations that had been completed in the past year. If an individual was receiving direct therapy support the following documentation was requested: OT/PT/SLP schedule in the home and off-site, if applicable; and OT/PT/SLP programs and monthly progress notes for the past year. Reviews of individuals' records indicated a need and/or a recommendation for OT and/or PT supports and services, but individuals were not receiving these supports. The OT and/or PT assessments completed for individuals did not include components the Settlement Agreement required. More specifically: ▪ At the time of the Independent Expert Team's onsite review, Individual #109 was not receiving direct PT and OT therapy. The community provider reported: "OT/PT/SLP see our individuals in the home, treat them, and then release them with recommended ROM exercises that we complete as recommended as a support." Individual #109's OT Recommendations, not dated, and PT assessment, dated 5/30/12, were not comprehensive, as they did not address the necessary assessment components (i.e., diagnoses and/or description of significant health care issues; health risk indicators; orthopedic concerns; musculoskeletal status, posture' functional mobility; functional performance of activities of daily living; communication; impact of health care issues on performance and therapeutic intervention; description of current therapeutic supports, including mealtime, positioning and alignment, and assistive technology; and baseline measurements where appropriate, as well as analysis of findings to provide a rationale for recommendation and intervention strategies). The absence of a comprehensive OT and/or PT assessment did not provide sufficient clinical data to assist in the development of a comprehensive PNS plan. ▪ Individual #285 was not currently receiving OT, PT, and/or SLP services and supports. His Nutrition assessment, dated 1/9/13, recommended: "would consider PT eval [evaluation] for exercise program and other ways to help consistently increase his physical activity such as a gym membership, mall walking or Wii Sport." His Medical Review, dated 3/14/14, recommended:

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		"obtain a PT evaluation for a formal exercise plan for weight loss for [Individual #285] as recommended by the dietician." The community provider did not provide comprehensive OT and/or PT assessments. ▪ Individual #200's Occupational Therapy Progress Charts were submitted for the time period of January 2013 to January 2014. An annual Occupational Therapy IPP Summary, not dated, stated: "[Individual #200] has been actively participating in therapy and making improvements with fine motor coordination and range of motion in his arms. [Individual #200] has elbow and hand splints which staff reports he tolerates well." There was no comprehensive OT assessment to provide rationale for his direct therapy. His annual progress note did provide specific measurable documentation of his progress with direct therapy. Individual #200's DDD Medical Review report, dated 4/23/14, included the following recommendations: o Would recommend consulting with occupational/speech therapy about elevation of head of bed and degree of positioning while in his recliner; o Encourage a follow-up speech evaluation regarding communication and specifically document results of breathing assessment. Individual #200 should receive comprehensive OT and SLP assessments to address his Medical Review recommendations, as well as to provide clinical data to support the development of a comprehensive PNS plan. ▪ Individual #254's Occupational Therapy Plan of Treatment Discharge, not dated, stated: "[Individual #254] has been discharged from occupational therapy at this time due to staff/RN request." Community Coordination Specialists and community providers should ensure therapy documentation is dated. Individual #254 did not have a comprehensive OT assessment, which should have provided the rationale for direct therapy. A clinical rationale also should have been provided for the discontinuation of the therapy. In addition, Individual #254 should receive comprehensive OT, PT, and SLP assessments to provide clinical data for the development of a comprehensive PNS plan. ▪ Individual #33 did not have comprehensive OT, PT, and SLP assessments to provide clinical data for the development of a comprehensive PNS plan. As stated in previous reports, the foundation of an adequate PNS plan and/or provision of therapy begin with comprehensive occupational, physical, and speech language therapy, and/or PNS team assessments. Such assessments should provide clinical justification for an individual-specific PNS plan and/or direct therapy to mitigate an individual's risk indicators. These assessments should consistently incorporate the necessary assessment criteria, including: diagnoses and/or description of significant health care issues; health risk indicators; orthopedic concerns; musculoskeletal status; posture; functional mobility; functional performance of activities of daily living; communication; impact of health care issues on performance and therapeutic intervention; description of current therapeutic supports, which would include mealtime, positioning and alignment, and assistive technology; baseline measurements, where appropriate; and analysis of findings to provide a rationale for recommendations and intervention strategies. The therapy assessments for the individuals reviewed were missing components as required

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		in the Settlement Agreement and/or therapy assessments were not present. Based on interviews with community providers and Community Coordination Specialists, securing therapists with expertise and experience in providing adequate services and supports for individuals with intellectual and/or developmental disabilities continued to be challenging. The provision of community-based training for clinicians (i.e., OTs, PTs, SLPs, Nurses, and Dieticians) should expand the knowledgebase of therapists in their understanding of physical and nutritional supports as well as functional communication. **Community-Based PNS Team Assessments** As discussed in the last report, as the State works with community providers and relevant stakeholders, the State should provide guidelines that define the expectation for a community-based PNS Team. These guidelines should include, at a minimum: ▪ Composition of a PNS team; ▪ Components of a PNS assessment; and ▪ Components of a PNS plan. For example, a PNS Team assessment should reflect an interdisciplinary team's problem-solving approach in the identification of the causes of an individual's PNS concerns, identification of risk factors, and proposed strategies to minimize the effects of these PNS concerns and risk factors. The PNS team assessment should include the following components: ▪ Identification of the individual's current risk factors, including risks that might have changed due to a change in the individual's status; ▪ Description of the individual's current PNS issues; ▪ Identification of when and why an individual had been referred to the PNS team; ▪ An analysis of assessment data as the foundation for recommendations, interventions, and other strategies to minimize the identified PNS risk factors; ▪ Individual-specific clinical indicators to alert staff to a change in status; ▪ Individual-specific triggers to be monitored and appropriate staff to monitor these triggers; and ▪ Proactive interventions with functional and measurable goals that work to reduce and/or mitigate identified risk factors. **Training and Behavioral Services** *Areas in which Less Oversight is Necessary* ▪ *Individuals typically had recent updates to their psychological evaluations.* *Areas Requiring Focused Effort* ▪ *With regard to skills training: Some individuals were not receiving consistent and adequate structured habilitation to address adaptive behavior, independence, and employment goals.* ▪ *With regard to Functional Behavior Assessment (FBA): Although during the April 2012 review, more*

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		individuals who required them had had FBAs completed, the quality, as defined in Section C56, continued to vary, and FBAs had not been completed or updated for some individuals with significant behavioral concerns. ▪ *With regard to Behavior Support Plans: review of BSPs continued to find issues related to their quality (e.g., lack of consistency of medical and psychiatric diagnoses with those included in BSPs and or FBAs; failure to identify goals related to appropriate specific, individualized target/challenging behaviors; failure to include all significant challenging behaviors in the plan; failure to include a replacement behavior that was related to the identified function of the challenging behavior; lack of adequate definition of specific, measureable, objective replacement behaviors; failure to include an active teaching procedure of adequate quality and/or intensity for replacement behaviors; inadequate data collection systems or data collection that did not reflect the behavior being taught or strengthened; and lack of collaboration between speech/language pathologists and behavior analysts with respect to BSP development, as appropriate). Procedures to ensure data integrity also were lacking. Monthly reviews often did not include information about target/challenging behavior, and as a result, the effectiveness of the plans could not be measured. Providers did not consistently review and/or alter treatment plans in response to significant events.* <u>Skills Training</u> With respect to "consistent and adequate structured habilitation," the following concerns were noted: ▪ The IPP for Individual #419 included only three programs (display pro-social behaviors, complete the steps of a home maintenance checklist, and follow work expectations per work shift). Based on this individuals, strengths, needs, and preferences, this did not constitute "consistent and adequate structured habilitation." ▪ The IPP for Individual #415 included only four programs (demonstrate pro-social behaviors; maintain sanitation of my restroom; complete work expectations and follow work rules; and identify the five Rights of my medication). Based on this individuals, strengths, needs, and preferences, this did not constitute "consistent and adequate structured habilitation." ▪ The IPP for Individual #77 included only two programs (pro-social interactions, and healthy food program). Based on this individuals, strengths, needs, and preferences, this did not constitute "consistent and adequate structured habilitation." ▪ The IPP for Individual #341 included only two programs ("complete all steps of my BSP program," and "initiate and participate in my daily schedule"). Based on this individuals, strengths, needs, and preferences, this did not constitute "consistent and adequate structured habilitation." ▪ Individual #417 appeared to participate in only two formal programs ("demonstrate appropriate social skills," and "maintain her personal hygiene by bathing"). Based on this individuals, strengths, needs, and preferences, this did not constitute "consistent and adequate structured habilitation." ▪ Monitoring of progress for Individual #132 appeared to be limited to tracking the number of

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		maladaptive behaviors (for which there was no BSP due to low frequency) and frequency of participating in community outings. No progress review was provided for the replacement behavior in her BSP ("positive and healthy daily living choices"), or for the other formal program listed in her IPP ("engage in . . . employment skills"). In some of the above cases, it was apparent that other goals were being addressed informally, or were being addressed more formally, but were not being tracked. In sum, the IPPs for individuals visited during this review did not consistently document adequate structured habilitation commensurate with their level of need and the level of resources invested in their supports. <u>Functional Behavior Assessments</u> Most individuals the Psychologist on the Independent Expert Team visited during this review appeared to have some form of functional behavior assessment completed as part of the process of developing a BSP. However, in most FBAs that providers developed themselves, concerns regarding quality were noted. There was little evidence that providers were making use of the FBA process in a meaningful way to develop adequate BSPs. Except for the FBAs the external consulting agency completed, FBAs appeared to be *pro forma* with little effort devoted to interpreting the results or integrating them into a meaningful behavioral formulation that would guide intervention planning, As noted above, this remained an area requiring focused effort. <u>Behavior Support Plans</u> Concerns about BSPs were discussed above with regard to Section B43. There were significant weaknesses in providers' approaches to monitoring individuals' progress on habilitation and behavior programs. For example: ▪ The Programmatic Report for Individual #415 consisted of tables of raw monthly data, but lacked any analysis or interpretation of the data, or any conclusion regarding effectiveness of the programs or need for revision or termination. Further, the monthly reports appeared to combine the data for all of the "Tasks" associated with a particular goal, reporting only this "Total" figure. This total, at least in this case, was a meaningless number because it combined data from very disparate behavioral objectives (including "show his Relapse Prevention Plan," "complete his Self-Evaluation Form," "act respectfully toward others," "initiate ten minutes of table talk," and "plan the week's activities in advance"). This might be another example of using Therap to do things it was not designed to do and failing to recognize that the output did not accomplish any meaningful goal with respect to monitoring of progress. ▪ The Programmatic Report for Individual #77 consisted of tables of raw daily data, but lacked any analysis or interpretation of the data, or any conclusion regarding effectiveness of the programs

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		or need for revision or termination. No monthly or quarterly reports were provided. ▪ The "Monthly Review" sheets for Individual #341, provided in response to a request for "Quarterly Reports," contained only a single percentage datum for each month for his BSP program; this datum was said to relate to "completing all steps of [his] BSP," but it provided no information regarding behavior rates for either acceleration or deceleration behavior. It was not possible to draw any conclusions about progress based on these data. ▪ The "Monthly Review" sheets for Individual #232 contained only cryptic notations and very obscure data. It was not possible to determine, on the basis of these review sheets, whether he was making measurable progress toward his goals. ▪ The provider for Individual #400 included a "Monthly Review" sheet for two of the individual's programs. The sheets contained only a single percentage datum for each month for her program, without any interpretation or analysis of the data with respect to progress toward the associated goal. One counter-example to the above was: ▪ The "Monthly Review Form" for Individual #286 was somewhat more useful in that it included a comments section ("Action Plan") that sometimes reflected analysis of the data and sometimes included brief discussion of the need for change. In general, it appeared that adequate monitoring of progress on individuals' programs, and appropriate action as a result of that monitoring, was generally quite weak across community providers. **Psychiatric Care** *Areas in which Less Oversight is Necessary* ▪ *For individuals in the community that BSDC psychiatrists follow, less oversight is necessary with regard to:* ○ *Completion of a comprehensive assessment of each individual receiving psychotropic medication, including a clinically justifiable, differential diagnosis consistent with DSM-IV-TR criteria;* ○ *Justification for the off-label use (being prescribed for non-FDA-approved indications) of medications;* ○ *Justification for the use of the older, first generation antipsychotics;* ○ *Efforts to minimize the dosages of benzodiazepines and anticholinergic agents and the amount of time these agents are used, as much as possible;* ○ *Minimization, as appropriate, and justification for intra-class polypharmacy; and* ○ *Medical monitoring of potential effects of psychotropic medication (e.g., completion of lipid panels, blood sugar, EKGs, etc.), due to the fact that with few exceptions, this testing appeared to have been completed.* ▪ *For individuals in this group in general:* ○ *Provision of psychiatric care by a psychiatrist or Nurse Practitioner with psychiatric clinical*

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		specialty; and ○ *Efforts to minimize the dosages of benzodiazepines and anticholinergic agents and the amount of time these agents are used, as much as possible.* *Areas Requiring Focused Effort* ▪ *Due to issues related to obtaining documents from community psychiatrists, the Monitoring Team has had limited ability to evaluate the psychiatric care provided to individuals in the community that non-BSDC psychiatrists follow. For individuals for whom community providers are responsible for coordinating healthcare, it was unclear why they were not requesting copies of psychiatric evaluations, treatment plans, notes, etc. As a result of the limited reviews thus far, the following areas require further review:* ○ *Completion of a comprehensive assessment of each individual receiving psychotropic medication, including a clinically justifiable, differential diagnosis consistent with DSM-IV-TR criteria;* ○ *Justification for the off-label use (being prescribed for non-FDA-approved indications) of medications;* ○ *Justification for the use of the older, first generation antipsychotics; and* ○ *Minimization, as appropriate, and justification for intra-class polypharmacy; and* ○ *Medical monitoring of potential effects of psychotropic medication (e.g., completion of lipid panels, blood sugar, EKGs, etc.).* ▪ *For individuals in this group in general:* ○ *Justification for use of doses that are above the generally accepted effective dose;* ○ *Adequate mechanism(s) for communication between medical and mental health providers, and these providers and the community providers responsible for individuals' coordination of care; and* ○ *Adequate systems for the identification and reporting of potential side effects, including competency-based training for staff responsible, as well as response to data from the side effect monitoring forms and potential drug-drug interactions in psychiatric notes.* ▪ *Psychotherapy services for most individuals who were included in the April 2012 could not be evaluated, because no information regarding the goals or outcomes of psychotherapy was presented. Involvement of therapists with the individuals' teams appeared to be quite variable. Treatment goals for psychotherapy services were not included in individuals' IPPs.* During this review, the psychiatric records were reviewed for a small sample of individuals that received supports from various community provider agencies. Specifically, eight individuals prescribed psychotropic medication, served by seven different provider agencies were included in the review. The following summarizes the findings from this review. The Independent Expert Team's previous reports have commented on the questionable validity and utility of the diagnoses of Impulse Control Disorder (ICD) and Intermittent Explosive Disorder (IED) in

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		individuals with intellectual disabilities. ▪ Of the individuals visited for this review, one (Individual #415) may have carried a diagnosis of ICD, though this was unclear. All of the consultation forms from his provider agency to his psychopharmacologist reviewed for this report (i.e., from 12/26/12 to 12/13/13) listed the following diagnoses: Anxiety Disorder, ICD, and Pedophilia. The individual's IPP of 1/17/14 and Psychological Assessment of 4/12/13 did not include the ICD diagnosis. The DD Program Specialist Nurse completed a Nursing Care review on 12/11/13, and suggested clarifying the psychiatric diagnoses. In the team's 1/17/14 follow-up meeting with regards to these recommendations, it was stated: "The team believes it [the psychiatric diagnosis] is clear since… [individual] had a new psychiatric diagnosis completed on 4/12/13 (as noted in the IPP...)" However, the diagnoses remained in conflict, with ICD still on the Provider Agency forms. As formal psychopharmacology notes were not seen, the Independent Expert Team reviewer could make no statement as to what diagnoses that provider was using, though she did sign off on forms that included the ICD diagnosis. ▪ Another individual, Individual #77, had a diagnosis of IED. One of the BSDC psychiatrists saw her in consultation, and had reasonably, in the opinion of the Independent Expert Team reviewer, questioned this diagnosis and suggested an alternative. As described below, it was not clear the individual's psychopharmacologist had considered the consultant's recommendation. In sum, it was positive that, as appropriate, DDD staff were requesting reviews of psychiatric diagnoses for which there did not appear to be sufficient justification. Prior reports have described how, as formal psychiatric notes from non-BSDC psychopharmacologists have not been provided, no determination could be made with regards to whether the documentation requirements of the Settlement Agreement were being met for those individuals, approximately forty in number. To better judge the scope of the issue, IPPs for those individuals were requested. Thirty were reviewed; two were not provided (i.e., Individual #157 and Individual #264, the latter probably not on psychiatric medication); and eight were in nursing facilities, so did not have IPPs. Assuming information in the IPPs was accurate, to address the requirements of the Settlement Agreement, eight had diagnoses that would require justification. Other justification in the records would be necessary as follows: nine were on interclass polypharmacy, three on high doses of medications, four on anticholinergic medications, four on typical antipsychotics, fifteen on medications off label, and eight on benzodiazepines. The Independent Expert Team provides this information for the consideration of the parties. When the parties discussed the Areas Requiring Focused Efforts, these remained areas in which the Independent Expert Team was asked to continue monitoring. However, without more thorough documentation for review, a complete review is not possible. For example, justification might exist for issues such as off-label use of medication or polypharmacy, but without documentation from the prescribing practitioners, the Independent Expert Team cannot evaluate it. The parties need to make a determination regarding how to proceed.

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		In response to a request from DOJ, the State provided raw data on the numbers of individuals that had transitioned to the community since October 2007, and that were prescribed psychotropic polypharmacy. Polyharmacy was defined as individuals prescribed three or more psychotropic medications or two psychotropic medications of the same class. Based on the list provided, the State identified 45 individuals, which did not include individuals residing in nursing facilities. Thirteen of these individuals were prescribed five to seven psychotropic medications. No data from 2009 was available for comparison. The data provided should be viewed cautiously, because without an analysis of the numbers of individuals for whom polypharmacy was appropriately justified, the pure numbers provided little meaning. The possibility had been raised in earlier reports that once a Managed Care system became involved in providing psychiatric medications, some of the issues with regards to documentation of need for high doses of medications and inter-class polypharmacy could be addressed. According to an interview with the BSDC Medical Director, at the time of the Independent Expert Team's April 2014 visit, the Managed Care company had not gone beyond decisions as to whether or not medications would be approved based on whether they were formulary or non-formulary. Psychopharmacologic management for the individuals seen during this onsite review in the community was assessed. Some positives were noted: ▪ While formal notes from psychiatric contacts for Individual #341 were not seen, he appeared to have adequate monitoring for some, but not all potential side effects of the medication. According to the note from his PCP of 1/30/13, Individual #341's psychiatrist had ordered warranted blood tests as she was prescribing Risperidone. The lipids were elevated, so he was referred to the PCP where a plan to normalize his lipids was initiated (i.e., medicines and dietary management). While formal follow-up after a 1/30/13 PCP contact was not provided to the reviewer, during the Independent Expert Team's April 2014 visit, the reviewer was told the medical interventions were helping to control his elevated lipids. It was not clear, however, whether necessary monitoring for potential emergence of a movement disorder was being done. No report of a screening test was provided for review. When she filled out the provider agency's form at the 3/6/14 appointment, his psychiatrist wrote, under "instructions/recommendations": "monitor for EPSE [movement side effects] and tardive dyskinesia [the movement disorder of most concern, for which AIMS screening is done]." It was not evident to the reviewer who she meant was to do the examination, or whether she had been doing them and planned to continue. At any rate, specific documentation of the required screening tests was not provided for the Independent Expert Team's review. ▪ A prior report discussed the issue that Individual #286's team was having problems getting his psychopharmacologist to respond to their concerns, but that they could not transfer his care as the individual's guardians wanted him seen by a psychiatrist. The guardians subsequently approved the transfer of his care to a nurse practitioner. Clinical staff the Independent Expert Team interviewed during this visit gave examples of how this nurse practitioner did respond rapidly to their telephoned concerns, for example stopping one medication (Lorazepam), when

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		they though it was "causing problems;" and on another occasion, decreasing the individual's Depakote dose when she was told he had become too sedated. The team told a member of the Independent Expert Team that the individual's family was also happy with the care the nurse practitioner provided. On the other hand, later in this report, there is a discussion of concerns the Independent Expert Team reviewer had with the lack of evidence of communication between the psychopharmacologist and the PCP with regard to the possible role one of Individual #286's medicines, depakote, (and perhaps, another: zyprexa) was playing on the individual's elevated liver enzymes and low platelet count. Some problems were also noted: ▪ As noted above, Individual #400 was a 24-year-old woman who had been on antipsychotic polypharmacy, Clozaril 350 mg a day and Trilafon at 52 mg a day, a very high dose, for at least seven years, though she had been doing well behaviorally, evidently with guardian input with regard to her medication regimen. The Federal Drug Administration (FDA) has suggested the normal range of Trilafon dose for outpatients be between 12 and 24 mg a day, with instructions to "reduce as soon as possible to minimum effective dose." The high dose of Trilafon the individual had been taking for such a prolonged period put her at a significant risk of developing tardive dyskinesia (abnormal potentially irreversible involuntary movements), the risk being associated with total antipsychotic dose taken over one's lifetime, and said risk being increased in females. In addition, the necessary abnormal screening was evidently not being done, an omission noted by the State's Nursing Care Review team. Although the individual had been doing well according to the provider agency's team and the forms filled out by the psychopharmacologist, from 2/12 to 11/22/13, there was no evidence presented that a trial of medication reduction had been considered. In addition, for Individual #400, a neurologist prescribed Dilantin for a seizure disorder. According to her provider agency's medication sheets from April 2013 to March 2014 (December 2013 form mislabeled December 2014), she had no seizures during this period (with the exception of the September 2013 note, when presence or absence of seizures was not mentioned). As formal psychiatric and neurological notes were not provided, the reviewer could make no determination as to whether it had been considered that the seizures, controlled by the Dilantin, might have been a side effect of the Clozapine the psychopharmacologist was prescribing (the development of seizures being a known complication of Clozapine treatment). In the opinion of the reviewer, it was warranted that the neurologist and psychopharmacologist have a discussion as to whether a trial of decreasing the individual's clozapine was indicated. ▪ One of the individuals reviewed, Individual #415, was prescribed Seroquel off label for "impulse control/aggression." He had various metabolic problems that might have been worsened by the Seroquel: obesity, sleep apnea, high blood pressure, high cholesterol, and borderline diabetes. The Seroquel dose, 200 mg per day, had not been changed during the time frame of the data provided for review, from 3/6/13 to 12/13/13. As formal notes were not provided, the Independent

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		Expert Team reviewer could make no comment as to whether this off-label use and the possible complications of it had been considered in the medical record. As noted with regard to Section B43, it did not appear this individual was undergoing necessary screening for potential abnormal movements. The MRT had picked this up and was working with the provider agency to have this essential testing done. ▪ Individual #77 was prescribed several medications off label for an Intermittent Explosive Disorder, 700 mg a day of Seroquel and 50mg a day of Topamax. She also had several metabolic problems that might have been negatively impacted by the Seroquel: obesity (the reviewer was told by the team during an interview this visit that she weighed approximately 340 pounds), elevated lipids, (which, as of her 10/1/13 blood tests, were being adequately controlled by two medications), and evidently sleep apnea. As formal notes were not provided, the Independent Expert Team reviewer could make no comment as to whether this off-label use and the possible complications of it had been considered in the medical record. The reviewer was not provided documentation that necessary abnormal movement screenings were being done. The possible sleep apnea was of concern. While it was not listed as a formal diagnosis on her IPP of 3/4/14 that document did state: "I had been prescribed a CPAP machine... available since 8/21/13. I frequently refuse to wear the machine.... Direct support staff working with me will continue to offer the CPAP machine to me for my daily use." Her Behavior Support Plan did not seem to include a goal of increasing her willingness to use the CPAP machine more frequently, nor did the IPP include strategies for direct support professionals to use to encourage her use of the machine. To the reviewer, this appeared relevant, as individuals with ID who have inadequately treated sleep apnea can have daytime anxiety, irritability, and aggression, and these symptoms were problematic for Individual #77 and her team. As formal notes were not seen, the reviewer did not know whether that possibility had been considered by her medical/psychiatric team, or what the current status of her possible sleep apnea was. If it were possibly worsening her behavioral issues, it certainly should have been addressed in her BSP. According to her IPP of 3/4/14, in March 2013, one of the BSDC psychiatrists saw her for a consultation. A member of the Independent Expert Team requested documentation of this consultation and subsequent contact between the consultant and the treating psychiatrist. The initial note from that contact did not exist. On 4/10/14, the consultant wrote a consultation that he said was based on his handwritten notes from the 2013 meeting and on his recollection. He reasonably questioned the diagnosis of Impulse Control Disorder, suggested an alternative medication strategy, and also questioned the impact of untreated sleep apnea on her behavior. He wrote that subsequent to the 5/6/13 consultation, he had had a face-to-face meeting with the treating psychiatrist where his recommendations were summarized. As of the time of the Independent Expert Team's April 2014 visit, none of these recommendations had been acted upon. ▪ Individual #417 had a significant problem with shakiness. According to the note from her 9/14/10 psychiatric contact, a neurologist had seen her for a consultation, had diagnosed drug-induced Parkinsonism, and had suggested changing her antipsychotic regimen (at that point Haldol 10 mg a day and Risperidone 4mg a day) to Seroquel or Clozaril. In response to this, on

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		9/14/10, the Haldol was stopped and Seroquel 150 mg a day was started. Her tremor evidently improved, but she escalated behaviorally so the doses were gradually increased. By 2/25/11, she was on Seroquel 400 mg a day and Risperidone 8 mg a day, the doses she remained on at the time of her April 2014 visit with the Independent Expert Team. At the time of that visit, she still had a prominent tremor of both upper extremities. The formal note of her 12/5/13 psychiatric contact was confusing. Under "Side Effects," the psychiatrist wrote: "None? UE [upper extremity] tremor. No Tardive Dyskinesia or Extra Pyramidal Symptoms." It was the impression of the reviewer that the drug-induced Parkinsonsism, which was manifested by the ongoing tremor commented on in that note, was in fact an extrapyramidal symptom. The following is from Wikipedia: "Extrapyramidal symptoms (EPS) are various movement disorders such as acute dystonic reactions, pseudoparkinsonism, Tardive dyskinesia or akathisia suffered as a result of taking dopamine antagonists, usually antipsychotic (neuroleptic) drugs" (Drug-induced Parkinsons is in the category "pseudoparkinson"). It was not evident to the reviewer there was a plan to address the ongoing tremor with the former neurological consultant or to consider his other recommendations from 2010 (i.e., transition off Risperidone). In sum, although it was positive that through consultation with DDD psychiatrists as well as the MRT reviews, some medication-related issues were identified, not all of the issues were identified, and, at times, even when they were, they went unresolved. As had been the case in prior reports, the provider agencies serving the individuals in the community visited for this report monitored side effects in different ways. ▪ The agency following Individual #415 and Individual #419 had a procedure where direct support staff filled out side effect forms daily, with the home manager collating monthly data. However, as described with regard to Section B43, while the forms for Individual #419 stated he did not have the side effect of elevated blood pressure, in fact his blood pressure had not been measured until an agency nurse corrected this problem. Moreover, as noted in a later section of this report, no evidence was presented for review that side effect data was routinely given to psychopharmacologists. ▪ The different agencies providing services to Individual #77, Individual #132, Individual #341, Individual #400, and Individual #417 had similar procedures. Medication side effect lists were obtained from the internet or pharmacies. If staff noticed anything, they were to report it to a program nurse (i.e., Individual #77's program), the residential director (i.e., Individual #341), or if the side effect sheet stated presence of a specific side effect warranted communication with a physician, reporting to the appropriate physician (i.e., Individual #132's). The agencies for Individual #77 and Individual #341 did not appear to have a formal time frame for when presence or absence of side effects were to be monitored. Specific side effect data for Individual #77 (who appeared to have the possible side effect of episodic sedation) was not provided for review. The data provided for Individual #341 was unclear. It was a listing of medications as dispensed. Perhaps if side effects were noted they were to be recorded there and none had been

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		noted. Individual #400's team was to report notable side effects monthly on her medication cards, using pharmacy side effect sheets as a reference. It was not clear who was responsible for this collection and/or discussion. No side effects were noted on her medication cards that were provided for review, from April 2013 to September 2013. Her Psychological Assessment of 12/12/11 stated she exhibited "twitching," which seemed to possibly have been a side effect from the high dose of Trilafon she was prescribed, 52mg a day. The status of that twitching was not clear. Individual #417's team collected side effect data daily and was to contact the physician if warranted. It was not clear how well this was working. Specific side effect data were not seen, but monthly aggregate data were provided. Between 10/5/13 and 3/5/14, she had some side effects noted on only three days. On the day the Independent Expert Team reviewer interviewed her, she had a marked tremor, which appeared to be a medication side effect. From discussion with the team and review of her psychiatric notes, it appeared to the member of the Independent Expert Team this tremor had been a long-standing issue, and it was unlikely it was as rarely present as the data suggested. ▪ Individual #286's team collected daily side effect data. His psychopharmacologist seemed to have been involved in picking which side effects to monitor, which the Independent Expert Team reviewer saw as positive. While there were varying approaches, none seemed to the reviewer as potentially effective as the side effect monitoring protocol that BSDC staff developed, which has been described in prior reports. BSDC medical and nursing staff developed a form, the Psychotropic Medication Monitoring Scale (PMMS) that staff began using in July 2012. Program nurses filled out this form when medications were started and stopped, and at least monthly while an individual was on psychiatric medications, discussing presence or absence of various side effects with direct support professionals. As has been previously discussed, the Independent Expert Team recommends DDD staff share this tool with community providers, and encourage its use. Priorities for Implementation and Review included the need for the Independent Expert Team to continue to monitor whether community providers ensured timely and complete follow-up to recommendations from medical providers. During this review, the following concerns were identified: ▪ Individual #286 had a history of elevated liver enzymes. He had a history of Hepatitis C and was also on Depakote and Zyprexa, two medications that could cause these problems. As formal medical notes, annual H and P, long-term history of liver issues and liver tests prior to the initiation of Depakote and Zyprexa were not provided for review, no determination could be made as to the medical team's diagnostic considerations. The individual was undergoing laboratory tests for his liver every six months, and episodic liver ultrasounds (specifics of the ultrasounds were not provided). On 1/20/14, the team sent a form to the PCP about how the most recent liver tests seemed elevated and wanted to know whether there should be a plan modification. The PCP wrote on the form: "lab similar to prior lab with 1/9/14 lab outlier," and that no change in plan was indicated. The Independent Expert Team reviewer agreed that the

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		liver tests had been fairly stable, and that the seeming worsening was because of an outlier (essentially, a lab error). The lab test that was an outlier was probably the previous test, from 10/10/13, which made the 1/9/14 values look so much worse. Perhaps this was what the PCP meant. Laboratory tests in question were as follows. Two enzymes that were markers for liver disease were being followed. ALT (normal range: 0 to 41) was 209 on 2/28/13, 334 on 7/9/13, 31 on 10/10/13, and 272 on 1/9/14. AST (normal range: 7 to 39) was 174 on 2/28/13, 318 on 7/9/13, 37 on 10/10/13, and 170 on 1/9/14. Of more concern, no evidence was provided to the Independent Expert Team that an interaction had occurred between the individual's PCP and psychopharmacologist with regards to the individual's liver status (which, as noted above, might have been negatively impacted by the psychiatric medicines) as well as to the individual's low platelet count (as low as 54,000 on 7/12/13, normal being 150,000 to 350,000). Platelets are blood cells that help stop bleeding. At counts below 100,000, mild injuries may provoke excessive bleeding, certainly an issue in people like Individual #286 with a tendency to hit themselves in the head. Lowering platelet counts is a known complication of depakote. No evidence was provided to the Independent Expert Team that the medical team had considered this. In fact, no evidence was presented that the psychopharmacologist had been made aware of the low platelet count. With regards to plan follow-up, in his IPP of 10/24/13, it was stated that at the individual's October 2013 appointment with his psychopharmacologist, a follow-up appointment was scheduled in December. At the IPP meeting, his guardian "felt strongly that" the individual "should be seen monthly through the holidays." This was to have been arranged by the provider agency. There was no evidence presented that this November 2013 appointment occurred, or the December appointment either, as the next form from a psychopharmacology contact was from 1/20/14. Perhaps all of the forms from contacts were not provided for review. There was none from the described October 2013 contact either, the form prior to 1/20/14 being from a contact of 7/15/13. A prior report from the Independent Expert Team described the varying quality of information communicated by different provider agencies to psychopharmacologists. This visit, the Independent Expert Team visited eight individuals, served by seven different provider agencies, who were receiving psychiatric services in the community, and another (i.e., Individual #232) who had no evident psychiatric needs. The information given to psychopharmacologist at appointments differed from agency to agency: ▪ The agency providing services to Individual #415 and Individual #419 made sure the psychopharmacologist were given good behavioral data. However, it was not clear that side effect data was routinely provided. ▪ The reviewer was not provided the information Individual #77's agency gave her psychopharmacologist. ▪ A form Individual #341's agency gave his psychopharmacologist stated that behavioral data was provided. There was no mention of side effect data. ▪ It was not clear what information Individual #417's agency provided her psychiatrist. His note of 6/26/13 stated: "PT at work-no data or narrative. No forms or data or narratives." The meaning

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		of this was not clear to the reviewer. In the MRT consultation of 3/7/13, the then physician member of the team noted that the individual had two BSPs, one for her residential program and one for day services. He wrote: "staff informed us that summary data from either of the BSP [sic] do not consistently go with... to the psychiatrist for her visit." ▪ It was not clear what information Individual #132's agency provided her psychiatrist, though it was evident from the psychiatrist's notes that there was discussion at those appointments of behavioral data. ▪ It was also not clear what information Individual #400's agency provided her psychiatrist. In an interview, her team stated they gave her psychiatrist a list of her medications and incident reports. On the Medical Contact Form from her 11/22/13 psychopharmacology appointment, it was written: "graphs given... for review." ▪ Individual #286's agency forms given to the psychopharmacologist did describe team concerns, both behaviorally and with regards to side effects, and side effect and behavioral data were noted clearly. In sum, from provider to provider, variances existed with regard to provision of behavioral and side effect data to psychopharmacologists. In general, it appeared that often behavioral data was provided, but side effect information was less often made available. **Speech Therapy and Communication** *Areas Requiring Focused Effort* ▪ *Speech therapy and communication assessments were often inadequate to meet individuals' individualized, functional communication needs.* ▪ *Collaboration between SLPs and psychologists/authors of BSPs in community settings was often missing or inadequate.* There were two individuals in the sample of 10 individuals (i.e., Individual #109, Individual #344, Individual #111, Individual #285, Individual #169, Individual #200, Individual #33, Individual #254, Individual #143, and Individual #65) who did not require speech therapy and communication services and supports. More specifically: ▪ At the time of the review, Individual #65 did not receive SLP services and supports. His IPP, dated 2/25/14, stated: "I am able to verbally communicate my wants/needs/emotions." ▪ Individual #285 did not receive SLP services and/or supports. His IPP, dated 1/8/14, stated: "I am able to communicate verbally to express my wants and needs. I am easy to understand and I am able to carry on full conversations with people." Community providers and Community Coordination Specialists continued to be challenged to find community-based SLPs with expertise in assessing and recommending AAC systems for individuals with intellectual disabilities. Eight individuals with communication deficits continued to not receive adequate SLP services and supports. Individuals' reviewed did not have speech language/communication

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		assessments and/or these assessments did not include components as required by the Settlement Agreement. More specifically: ▪ Individual #111's Speech/Language Evaluation and Plan of Care, dated 9/27/13, indicated IDT members requested a SLP assessment: "because they would like [Individual #111] to learn to communicate his wants/needs since he is non-verbal." His SLP assessment did not contain the necessary components. Most importantly, the assessment did not include a comprehensive assessment to determine if he would benefit from the use of an alternative and/or augmentative communication device or system. His assessment's long-term goal was to "increase communicative intent through purposeful interaction during therapy sessions." Documentation submitted identified approval of speech therapy for September 27 to November 27, 2013; February 1 to 31, 2014; and March 1 to 31, 2014. His IPP, dated 10/17/13, stated: "services (i.e., SLP) has been discontinued due to unsuccessful implementation of communication devices/tools and his tactile defensiveness." ▪ Individual #33's nursing facility plan of care stated: "difficulty with communication and decision making skills related to MR and poor hearing." Individual #33 had not received a comprehensive SLP assessment to assess her potential for augmentative/alternative devices to assist her in being able to communicate functionally. ▪ Individual #200's IPP, dated 2/27/14, noted: "I want to improve my communication with staff and friends." Individual #200's community provider did not provide a comprehensive SLP assessment, and he was not currently receiving SLP services and/or supports. His DDD Medical Review, dated 4/23/14, indicated: "recommendation to encourage a follow-up speech evaluation regarding communication and specifically document results of breathing assessment." ▪ Individual #254's IPP, dated 7/26/13, stated: "I am non-verbal, however make vocalizations, facial expressions, and use waving my arms/hands as primary form of communication." Individual #254's community provider did provide a comprehensive SLP assessment. ▪ Individual #169's IPP, dated 12/3/13, indicated: "I am non-verbal, but I am skilled at communicating with my eyes, by my facial expression and by my body language. Those that know me well can interpret my facial expressions, vocalizations, and body language." The following statement was provided: "[community provider] is still waiting on therapy notes, and assessments from [therapy provider]. Multiple attempts have been made to coordinate therapy notes sent to the home and they have been unsuccessful. The team will continue to request the therapy notes for all PT, OT and speech services and will forward when received." Documents were provided approving speech therapy for February 1 to 28, 2014, and March 1 to 31, 2014. However, no comprehensive SLP assessment was provided for Individual #169 to provide the rationale for the provision of direct speech therapy. ▪ Individual #344's IPP, dated 12/5/13, noted: "I communicate non-verbally by facial expression, body movements, gestures and vocalizations. I let people know when I am upset by vocalizing." Individual #344's community provider did not provide a comprehensive SLP assessment. ▪ Individual #109's IPP, dated 6/18/13, reported: "I use facial expressions and will reach for things I want. I reach out for peers or staff I want to communicate or interact with me." Individual

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		#109's SLP assessment, dated 1/4/13, included this recommendation: "short term outpatient speech therapy services to trial various low tech augmentative strategies/devices to determine appropriateness for [Individual #109's] use." His one-page SLP assessment was not comprehensive and did not address the necessary assessment components. In addition, there were no speech therapy notes to address his short-term therapy for AAC device trials. ▪ Individual #143's IPP, dated 5/7/13, indicated he had communication deficits. He did not have a comprehensive SLP assessment to assess his potential for augmentative/alternative devices. As stated in previous reports, the State should consider developing therapy assessment content guidelines (i.e., OT, PT, and SLP) that would assist Community Coordination Specialists and community providers in requesting specific assessment content from a therapist when a referral is made for therapy assessments. As stated in previous reports, community providers should seek qualified speech language pathologists with expertise in alternative and augmentative communication. A SLP should complete a comprehensive assessment to identify an individual's functional skills, interests, and preferences. Such assessments should incorporate observation, as well as clinical assessment, and include an analysis of the assessment data in a manner that identifies an individual's strengths and potentials for functional communication. The SLP assessment should address, at a minimum: diagnoses and/or descriptions of significant health care issues; health risk indicators; functional communication; receptive and expressive language skills; swallowing and functional oral motor skills, as they relate to eating, drinking, and speech; voice and articulation; functional reading skills and literacy; the assessment, selection, and training for AAC communication aids and devices; the impact of health care issues on performance and therapeutic interventions; and a description of therapeutic supports, including mealtime supports. Assessments should include baseline measurements, where appropriate. Comprehensive assessments should include recommendations that the individuals' teams can use to develop functional, measurable outcomes and goals/objectives. Little progress was noted with respect to "Collaboration between SLPs and psychologists/authors of BSPs" during the most recent review. Specifically: ▪ The Team Behavior Consultation team had not yet included speech/language professionals on the team. ▪ There was no evidence of collaboration with SLPs in the writing of BSPs in community provider agencies. In summary, Speech therapy and communication assessments continued to be often inadequate and/or were not present to meet individuals' individualized, functional communication needs. **Monitoring by Service Coordinators** *Areas Requiring Focused Effort* *Although a number of improvements had been made, a system did not yet exist that consistently identified the*

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		issues related to the adequate provision of protections, services, and supports to individuals the Settlement Agreement covers. As the Settlement Agreement implies, such a system should include, but not necessarily be limited to service coordination services. As is discussed later with regard to Section B48, incident management and the abuse/neglect system are parts of the State's oversight system, and as discussed with regard to Section B53, so are the survey/certification and the complaint systems. However, specifically in relation to the service coordination monitoring, the following were areas in which focused efforts were needed: ▪ *Refinement of monitoring tool(s), including adequate instructions to assist in ensuring reliability and validity of findings, and to ensure that the quality of supports and services, including clinical supports are adequately assessed and/or referrals made for further assessment by DDD's clinical staff. This can be done using simple instructions that do not result in an extremely lengthy document. A number of specific recommendations are made in the Monitoring Team's report, but for example, this could include more definition of when Service Coordinators need to contact someone else, including triggers. The Chief Medical Officer and State Office nursing group should help provide individualized monitoring tools;* ▪ *Development and implementation of competency-based training for Service Coordinators on monitoring tool(s), including development of system for assessing inter-rater reliability;* ▪ *Memorialization/standardization of process used to notify providers of concerns identified through Service Coordination monitoring, and tracking of follow-up though to completion; and* ▪ *Finalization and implementation of process for aggregating, analyzing, and acting upon data collected through Service Coordination monitoring.* With regard to CCS monitoring, at the time of the Independent Expert Team's last review, the State provided the following update: "… After review of the monitoring tool that is available in test format on the DDQA website, the Transition Manager and Deputy Administrator for QI came to the realization that the tool in its current format does not offer the state the kinds of data that is useful for quality improvement measures. In addition, the questions were difficult for CCSs to interpret and answer. The state proposes to modify the current system which will then [be] incorporated into the monitoring tool used by all service coordinators across the state as it is introduced on Therap…" Based on staff interview during the current review and review of the DDD Updates, in 2013, a QI Subcommittee was initiated with the task of developing and addendum to the existing monitoring form to better assess the supports and services provided to individuals with specific behavioral health or health needs. The subcommittee developed an addendum and instructions. On 1/1/14, CCSs supporting individuals the Settlement Agreement covers began piloting the new tool. In April 2014, a second subcommittee was initiated to revise and update the general monitoring form all Service Coordinators use. According to the DDD Updates: "the emphasis will be on improving the data collected, evaluating the quality of services and analyzing the outcomes for individuals as defined within our HCBS waivers, regulations, and expectations."

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		Overall, the Independent Expert Team supports the idea of a general tool, and then a more specific tool(s) to address the needs of individuals with more complex needs. In the Independent Expert Team's last report, comments were provided regarding the draft addendum. Some of these recommendations were incorporated into the next draft of the addendum. The following comments are offered regarding the most recent iterations of the audit tools: ▪ With regard to behavior supports, CCS monitoring forms for recent months employed a significantly altered format from the previous one. Two items on the form directed Coordinators' attention to "review of incident reports, observations, staff reports" and "observations/incident reports, staff report" in order to determine whether behavior strategies were implemented as written and continued to be appropriate. Further, the addendum being piloted addressed more specifically potential problems with the FBA, BSP, and Safety Plan. These revisions appeared to be reasonable efforts to support CCSs in more carefully monitoring behavioral assessment and treatment, although they had not been in effect for much time and it was difficult to assess whether they were leading to provider action when it was indicated. There was some concern that the weaknesses noted elsewhere in this report were never identified by the CCS' monitoring. For example, items related to behavioral assessment and treatment were consistently marked "yes" (i.e., adequate) without comment, suggesting that CCSs might not have had the resources/knowledge needed to detect existing problems. ▪ The addendum included some important components of the treatment and supports that individuals with complex needs require. However, some were not addressed, or not addressed fully. For example, many individuals receive psychiatric supports, and require community providers to assist them in communicating data related to symptoms and side effects to their psychiatrists. However, the draft addendum did not address these supports. ▪ As stated in the previous report, the Community Coordination Specialist monitoring form also should include additional indicators and instructions to support adequate monitoring of health and PNS services and supports. More specifically: ○ The indicators and/or instructions should define the type of assessments that should be considered and/or secured when an individual receives a rating of high and/or medium based on a screening. Guidance should be provided outlining the minimum content that should be provided in the assessment. These guidelines should assist the CCS in monitoring the quality of the assessment. ○ Indicators with instructions should be included to evaluate the team's consideration of the assessment recommendations, their inclusion in the IPP or justification for not including them, and their implementation, as appropriate. ○ Indicators with instructions should assess whether or not the components of a PNS plan or other appropriate document/plan addressed the needs of individuals at high and/or medium risk for PNM concerns. ○ The monitoring process and form should include observations to assess whether the PNS and nursing care plan are being implemented (e.g., staff are compliant with PNS or other plan instructions for lifting, transfers, mealtime, oral care, medication administration,

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		personal care, and bathing). ○ To address changes in status, monitoring indicators and instructions should be included to assist Service Coordinators in evaluating when an individual's needs have changed, and, if so, if related plans have been updated to meet the individual's needs. ○ The instructions should define when onsite follow-up should occur after problems have been identified through the monitoring process. For example, for emergent issues and/or ones that threaten the health and/or safety of an individual, onsite verification that the underlying problems have been addressed should occur within a short period of time in addition to the review of documentation the provider submits. The instructions did not, but should identify actions teams should consider or the instructions should refer CCSs to another document or procedure that includes this information. Actions that teams should consider would include, but not be limited to holding a meeting to consider revision of the IPP, rescreening for at-risk conditions or changes in status, or requesting assessments. ▪ Indicator #8 stated: "Has there been documented follow-up by the Provider and team related to an incident(s) identified as reportable by 404 NAC regulations and the General Event Report Guide for Nebraska?" This addition of this indicator was constructive, but again, the quality of the follow-up did not appear to be contemplated by the question or in the instructions (i.e., the wording suggests that documentation is required, not that the documentation showed sufficient action to address potentially underlying causes of the incident). The State had begun this initiative with the goal of improving its ability to collect data that was useful in the overall quality assurance/improvement processes. It is positive that the State was taking these steps. Once the tools are finalized with the inclusion of valid measures, next steps should include competency-based training, establishment of the reliability of the data, and then, analysis and use of the data to identify and correct individual as well as systemic issues. In summary, additional work remained for CCSs to accurately monitor the provision of services and supports for individuals with complex medical, physical and nutritional, and/or behavioral health needs, and for the data to then be aggregated and analyzed, with corrective actions taken as necessary. For such data to be useful, the data will need to be both reliable and valid. This is an area in which continued focus was needed. **Incident Management** *Areas in which Less Oversight is Necessary* ▪ *The State had set up an electronic system for community providers to enter incident data. Data entry has been ongoing for several months. Although, as discussed below, some issues related to the quality of the data understandably required correction, this was a notable improvement. Use of this electronic system provided the State with a tool to collect information in a timely manner, as well as to be able to aggregate information, and generate reports that would assist in the analysis of*

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		incident and other data. It also provided easier access to and use of incident data by a number of audiences, including State staff (e.g., Service Coordinators, survey staff, quality improvement staff, investigators, administrators, etc.), as well as community providers. *Areas Requiring Focused Effort* ▪ *As the State had identified, with the implementation of the new regulations and new electronic reporting system, the State needed to address issues related to the quality of the data providers were entering (e.g., the correct incident categories). This was important to ensure the data was usable to allow adequate analysis on an individual as well as systemic level.* ▪ *The electronic system provided a mechanism to track follow-up to incidents, including electronic review and sign-off from a number of people such as the Service Coordinator. Although a number of improvements were seen, sometimes, incidents were closed without the right questions being asked to confirm the cause of the incident and/or to ensure adequate follow-up occurred. It remained somewhat unclear if these were documentation or practice issues.* ▪ *For the April 2012 review, in response to two document requests through which the Monitoring Team sought information about the State's use of aggregate data to analyze the provision of protections, supports, and services (i.e., pre-review requests #II.16 and II.17), the State provided no documents. As a result, it did not appear that the State was yet analyzing data on a more systemic level or developing corrective actions, as appropriate, based on the information collected. This is an essential component of an adequate incident management system.* ▪ *Based on the new regulations, community providers were responsible to submit aggregate reports to DHHS every quarter summarizing and analyzing incidents. They were required to analyze the information for trends, and "take appropriate corrective actions to address problematic practice identified." Based on documents submitted, this generally was not occurring.* ▪ *Verbally, the State indicated that Service Coordinators and survey staff were reviewing incident data prior to or as part of their reviews. In the samples the Independent Expert reviewed, it did not appear that potential trends consistently were being identified, and/or addressed through adequate corrective action.* ▪ *Although the State had scheduled training for community providers to certify some of their staff as investigators, review of samples of investigations have revealed a wide variety in the quality of community provider investigations, including some poor investigation practices resulting in substandard investigations. In addition, based on the Monitoring Team's discussions with provider staff, community provider staff responsible for investigations had had varying levels of training on the investigation process, often using training modules the community providers had developed. Expectations or standards for community provider investigations had not been developed.* ▪ *A system was not in place yet to share the results of mortality reviews with community providers. The lessons learned, and a number of the recommendations included in Mortality Review Committee reports would be beneficial for all community providers to be made aware of, and to use to evaluate their own policies, procedures, and systems. During the April 2012 review, this was discussed in more detail with DDD staff, including the Chief Medical Officer. Staff indicated that they would*

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		investigate the possibility of issuing reports summarizing data, and important findings, while still maintaining confidentiality requirements. Quality of Data Community provider agencies are required to report incidents as outlined in the 404 NAC regulations. In previous reports from the Independent Expert Team, concerns were noted about the quality of the data collected on incidents, including concerns about the "other" category, which made it difficult to determine the nature of the incident without reading the description. Documentation the State submitted indicated: "Since 2010, the Division has recognized that provider agencies across the state completed the online 'General Event Report' inconsistently. As a result, this inconsistency in reporting resulted in some limitation in the Division's ability to analyze aggregate data." As indicated in the last report, recognizing these concerns, the QI Committee formed a workgroup, and since the last review, DDD issued a written guide that listed the type of incidents that must be reported to DDD, and identified the appropriate category within the online reporting system. It was entitled: "GER Instructions: Department approved format for written reports of incidents by Community Based Providers," effective 1/1/14. Review of the guide showed it to be very helpful in providing instructions for the completion of GERs, as well as guiding providers in relation to what incidents they were required to report to DDD (i.e., high notification level) versus those providers should track internally (i.e., low or medium notification level). It set forth a reasonable set of incident types, and the categories into which they fell. It also provided a good list of injuries, and delineated the reporting requirements for these as well. At the time of the Independent Expert's onsite review, community providers had been implementing the guide for a couple of months. Reportedly, it was helpful in improving the quality of data. Over time, DDD should conduct reliability checks to ensure providers are reporting incidents (e.g., as part of the survey process) and categorizing them correctly (e.g., random checks). As necessary, DDD should make clarifications to the guide to address any issues with regard to the definitions or categorization system. This was an area that in which good progress was made. Ongoing vigilance will be needed to ensure providers follow the guidance the State has provided. Closure of Incidents In past reports, the Independent Expert Team identified that sometimes incidents were closed without the right questions being asked to confirm the cause of the incident and/or to ensure adequate follow-up occurred. During the last review, improvement was noted. For this review, based on a review of 15 of the most recent critical incident reports submitted to DDD for individuals the Settlement Agreement covers, sufficient follow-up was noted. One incident appeared to still be open (i.e., it appeared a complaint was filed on behalf of Individual #66, but the results were not included) For the remaining 14, 13 of 14 (93%) showed appropriate follow-up by the CCS. The following was the only concern noted during the current review of documentation:

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- Individual #182 had a seizure, and the description indicated: "Staff sat with her on the floor and observed that [Individual #182] became cyanotic during the seizure and for about 2 minutes afterwards…" It did not appear that provider nursing staff were contacted, and there was no indication whether her seizure protocol addressed what should happen if she became cyanotic. No follow-up to this issue was documented.

Based on review of the sample of the most recent incident reports, it was positive that improvements were maintained. This is an area that the Independent Expert Team recommends less oversight is needed.

Analysis of Incident Data

A concern noted in previous reviews was the limited review of incident data documented in minutes from the Quality Improvement Committee. Since the last review, the minutes reflected submission to the Committee of charts and statistics for incidents that community providers were required to report to DDD. The Committee discussed what appeared to be improvements in data since the GER Guide was issued. However, in-depth analysis of the data and/or identification and discussion of trends was not evident in the minutes available at the time of the Independent Expert's onsite review.

On a positive note, since April 2013, DDD Technical Assistance staff began to use incident data to identify individuals with high numbers of behavioral-related GERs over a 60-day period. For individuals with 10 or more, further analysis is completed to determine whether the individual is served through exception funding, or has been referred to TBC. If not, then Technical Assistance staff contact the CCS to recommend TBC referral. This showed good use of incident data. Based on interview, surveyors also reviewed incident data as part of the certification process, and the Nurse Specialists indicated they reviewed hospitalization reports.

This continued to be an area requiring continued focused efforts.

Mortality Reviews

In calendar year 2013, 10 deaths occurred, including one individual living at BSDC, three in nursing facilities, and six living in community settings. In 2014, thus far, 13 individuals died, including two living at BSDC, four living in nursing facilities, and seven in community settings. The following chart lists the mortalities with the cause of death as provided by the State in its census list, or in the mortality reviews conducted. As discussed in further detail below, the State should conduct further analysis of the information related to deaths, including information included in the mortality review reports. Without such analysis, the following information should be interpreted cautiously:

Individual	Residence Prior to Death	Date of Death	Cause of Death
Individual #172	Community ICF/ID	1/25/13	Cardiopulmonary Arrest

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Individual #43	BSDC	2/20/13	Respiratory and cardiac arrest, (due to) recurrent pneumonia, (due to) hypernatremia, (due to nephrogenic diabetes insipidus
Individual #392	Community	2/23/13	Bile Duct cancer
Individual #136	Community	2/28/13	Respiratory Failure
Individual #324	Nursing Facility	4/18/13	Dementia
Individual #171	Nursing Facility	9/15/13	Pneumonia
Individual #308	Nursing Facility	9/16/13	Pneumonia, due to profound disabilities
Individual #74	Community	9/24/13	Sepsis due to mid gut volvulus
Individual #75	Community	9/30/13	Cardiopulmonary arrest, due to aspiration pneumonia, due to dysphagia
Individual #123	Community MSU	11/12/13	Respiratory Failure
Individual #234	Nursing Facility	2/4/14	Colon and Stomach Cancer
Individual #219	Nursing Facility	2/13/14	Multi-system organ failure, with decline in function and anorexia
Individual #310	Community EFH	3/12/14	Respiratory Failure due to chronic aspiration
Individual #364	Community CDD	4/7/14	Dysphagia with pulmonary aspiration
Individual #374	Nursing Facility	4/19/14	Cardiopulmonary arrest
Individual #390	Community ICF/ID	4/30/14	Acute encephalopathy due to seizure disorder
Individual #288	Community CDD	5/8/14	Acute respiratory distress as a consequence of severe sepsis and pneumonia
Individual #223	Community ICF/ID	5/25/14	Pending
Individual #64	Community CDD	5/26/14	Pending
Individual #146	BSDC	5/27/14	Cancer
Individual #73	Community MSU	7/5/14	Pending
Individual #147	Nursing Facility	8/22/14	Pending
Individual #96	BSDC	10/8/14	Dysphagia with pulmonary aspiration

In its reports, the Independent Expert Team consistently has recommended that the State identify a mechanism to disseminate relevant information and recommendations from mortality reviews to community providers. This relates to the requirements in Section B48 to provide adequate protections to individuals, and Sections D107 and D108 that require the State to address systemic issues from mortality reviews. Given that the mortality review process continued to identify issues related to healthcare that potentially impacted the individual's death, as well as general concerns about healthcare provided to the individual in the months prior to his/her death, this would be valuable information to share with community providers so that they can apply lessons learned to their own practices.

In April 2014, DDD provided the Independent Expert Team with a copy of a report entitled: "2013 Summary Information pertaining to Death of Individuals receiving Developmental Disabilities

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		Community-Based Services." The report included a number of charts and graphs, as well as narrative breakdowns of some important data. This was a helpful first step in the analysis of data related to deaths. At a 2/17/14 meeting of the Nebraska Association of Service Providers, DDD shared some of this data with community providers. Necessary next steps include more in-depth analysis of the information. For example, analysis should be conducted to determine whether or not changes in practice might reduce individuals' risk. Such in-depth analysis is necessary to make the information meaningful and usable for providers, and so that as a system, the data can be used to identify areas in need of attention. Such analysis might lead to the development of action plans, and/or given the historical nature of some of the information, lessons learned that might impact future policy. Some examples of analysis that could be completed include, but are not limited to: ▪ For deaths in which providers received regulatory citations, were there themes that required systemic attention? ▪ Did deaths that law enforcement investigated result in any findings? ▪ Was cardiopulmonary resuscitation (CPR) administered in all cases in which it was warranted? For example, when emergency services were called, did community provider staff administer CPR until help arrived? ▪ For specific causes of death, analysis could be completed to determine whether or not individuals had been identified at risk for such conditions, and, if so, whether proper plans were in place, and implemented? For example, for individuals with deaths that relate to aspiration, other respiratory compromise, bowel impaction, etc., it would be important to determine whether they had physical and nutritional supports identified to minimize risk and whether they were implemented (e.g., by reviewing IPPs and CCS monitoring reports). If not root cause analysis to determine reasons for lack of services would be necessary to determine actions needed. ▪ For individuals for whom mortality reviews or investigations were completed, were trends identified with regard to recommendations? ▪ In looking at rates of deaths per community provider, it would be important to analyze the data in light of the level of acuity of the individuals the provider supports. As noted above and in the last report, with the introduction of the two community nurses and greater involvement of the CMO in the community system, some work had begun to address some of the systemic issues identified through mortality reviews, such as the need for better nursing care plans and oversight. Likewise, the DDD Survey and Certification unit had begun to conduct reviews when individual issues or more systemic concerns were identified. The State was not currently documenting resolution or progress towards resolution of systemic issues that the external mortality reviewer identified. It will be important for the State document resolution or progress towards resolution of systemic issues the Mortality Review contractor has identified, as well as any trends it identifies as part of a more thorough analysis of data available. During the May 2014 onsite review, State staff explained that a previous attempt for DDD to develop a

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		Mortality Review Committee had been difficult, because such a Committee did not have the authority necessary to require the production of records, and/or the ability to require that recommendations resulting from reviews be followed. This appeared to be due to a lack of regulatory or other legal authority for these functions. In order for significant improvement to occur with regard to the mortality review process, such regulatory authority would need to be provided and a Mortality Committee would need to be formed comprised of State QI staff, legal staff, physicians, RNs, representatives from the provider community, and advocates/family members/individuals served. This Committee would then need to make recommendations based on a review and discussion of the external mortality review reports, or conduct its own mortality reviews. The MRC could accept or reject the external mortality reviewer's recommendations and create new ones when appropriate for implementation by State and/or provider staff. Annual reports could then be generated listing a summary of the recommendations and their implementation status, which would be helpful in determining and/or improving the quality of services. Although some progress had been made with regard to developing a report that summarized data related to deaths, more in-depth analysis of the data was needed, as well as documentation of follow-up activities related to any problematic trends identified. **Allegations of Abuse and Neglect** *Areas Requiring Focused Effort* *The Division of Children and Family Services (DCFS) had primary responsibility for the investigations of abuse and neglect investigations in the community. Community providers also played a role in investigations, which as described above, often were inadequate. Community providers also played a role in protecting individuals once an allegation was made, as well as in taking appropriate corrective actions once investigations were completed.* ▪ *As detailed in the Independent Expert Team's reports, in order to adequately protect individuals the Settlement Agreement covers, adequate regulations related to abuse and neglect were needed. The current Adult Protective Services (APS) Act did not adequately define abuse, neglect, and exploitation. As a result, DCFS was not investigating many allegations. Based on the Monitoring Team's discussion with the new Director of the Division of Children and Family Services, a committee recently had been formed and assigned the task of updating policies, and making proposals for regulatory revisions.* ▪ *At the time of the April 2012 review, DCFS was working with DDD to develop a pilot project through which DDD's certified investigators would conduct investigations of allegations related to individuals the Settlement Agreement covers. It was anticipated that DDD would have the opportunity to conduct an investigation based on their policies and regulations. Once completed, the investigation would be shared with DCFS. In making conclusions, DCFS would need to apply its definitions, which again were limited by current regulations. Even though it would not solve all of the issues, this collaboration appeared to be one that would assist in improving the investigations.* ▪ *At the time of the review, DCFS was responsible for completing the investigations. Review of a*

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		sample of investigations showed numerous problems with regard to their timely and thorough completion. The only two pieces of the investigation process that appeared intact were notification of law enforcement of relevant allegations, and the inclusion of a summary of the incident in investigation reports. Areas in which focused efforts were needed included the need for investigations and resulting reports to: ○ *Commence in a timely manner;* ○ *Confirm and document that adequate actions were taken to protect the individual immediately, such as evaluation by nursing staff of the individual;* ○ *Ensure that investigations were conducted in a manner so as to not compromise any criminal investigation;* ○ *Include an adequate summary of the investigation;* ○ *Include a chronology of events;* ○ *Include adequate review of evidence, and/or an adequate reconciliation of the evidence to provide an adequate basis for the findings;* ○ *Include adequate recommendations;* ○ *Conclude in a timely manner (i.e., 30 days).* ▪ *A system was not in place for DCFS to notify community providers when an allegation was called in, so that the community provider could take the necessary action to protect the individual(s), including but not limited to removing the alleged perpetrator from direct contact with individuals. A process was in place for DCFS to notify the Service Coordinators and/or DDD survey staff. They had taken on the responsibility to notify community providers.* ▪ *A system was not in place for DCFS to notify community providers of the results of investigations, so that appropriate programmatic and personnel follow-up action could be taken in a timely manner. Providers reported that often they found out the results of the investigations only when they completed annual Registry checks.* As noted in previous reports, on June 2012, a Memorandum of Understanding (MOU) was signed between the Division of Developmental Disabilities and the Division of Children and Family Services. The agreement set forth the requirements for notification of allegations of abuse and neglect, and determination of whether or not the individual allegedly subjected to the abuse or neglect is or was a resident of BSDC. According to the agreement, for individuals the Settlement Agreement covers, DDD had responsibility to conduct a complaint investigation. The DDD investigation report was available to DCFS, along with DDD's recommendation of action. DCFS also conducted an investigation. Responsibility for further action rested with DCFS in terms of determining whether abuse, neglect, or exploitation had been substantiated. DDD and DCFS had taken steps to make sure staff from both divisions understood their responsibilities under the MOU. On 4/22/13, DCFS issued the Protection and Safety Update #11-2013. It clearly set forth the responsibilities of Adult Protective Services (APS) staff in the process of conducting investigations for individuals the Settlement Agreement covers. As described in previous reports, DDD also had shared

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		training resources with APS with regard to conducting investigations involving individuals with intellectual and developmental disabilities. In addition, DDD and APS continued to hold monthly coordination meetings. At these meetings, issues regarding specific investigations and/or overall barriers were being discussed. At the time of the Independent Expert's onsite review, DCFS was in the final stages of rolling out a system to notify community providers of allegations when they were reported to DCFS. APS now had an on-call system across the State. When an alleged perpetrator was identified, the intake worker would notify the on-call investigator, who would in turn contact the provider to ask that the alleged perpetrator be placed in a position that involved no contact with individuals served. The on-call system also would allow implementation of investigation activities that needed to occur quickly. It was anticipated that on May 1, 2014, this new process would be implemented. This was a significant accomplishment and the Independent Expert Team appreciates DCFS' commitment and effort to resolve this issue. A sample was requested of 10 recent investigations, including the DDD investigation reports/complaint reviews that corresponded with the APS reports. The Independent Expert appreciates the State's efforts to coordinate this information. The documents were well organized, which facilitated their review. Based on review of the documentation for the 10 investigations submitted (i.e., Intake #527838; Intake #518111; Intake #522597, Intake #523334, Intake #513586, Intake #525520, Intake #516571, Intake #510559, Intake #528769, and Intake #530098), the following findings are made: ▪ Six of 10 (60%) commenced in a timely manner (i.e., within one working day). Those that did not included: #518111, #513586, #528769, and #530098; ▪ For six of the six (100%) that required such documentation, there was confirmation that adequate actions were taken to protect the individual immediately, such as evaluation by nursing staff of the individual and/or removal of the alleged perpetrator (i.e., #527838, #522597, #525520, #516571, #528769, and #530098). Of note, though, this was confirmed through documentation that the investigator ultimately obtained from the provider, but was not a result of APS contacting the provider immediately to report the allegation, and confirm that appropriate actions were taken; ▪ One investigation (i.e., #518111) involved a co-occurring criminal investigation, and the one (100%) was conducted in a manner so as to not compromise the criminal investigation; ▪ All 10 (100%) included an adequate summary of the investigation activities. This was based on a comparison of the investigator notes provided and the summaries in the final reports. Of note, however, as discussed in greater detail below regarding adequate bases for the findings, often necessary investigation activities had not been completed, or were not documented as having been completed; ▪ None of 10 (0%) included a chronology of events; ▪ Seven of 10 (70%) described necessary interviews. Those that did not included: #513586, #525520, and #528769;

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		▪ In one (i.e., #525520) of two applicable investigations (50%), evidence was adequately safeguarded. The one for which it was not was #530098. According to the investigation report, no photographs were taken of the individual's injuries, and the APS investigator did not see the individual face-to-face until a week after the allegation was made. Of note, the CCS's notes indicated she took pictures and sent them to the investigator; ▪ Three of 10 (30%) included adequate review of evidence, and/or an adequate reconciliation of the evidence to provide an adequate basis for the findings (i.e., #518111, #516571, and #510559). As noted in the previous report, although based on the case notes, it appeared that investigators were using some improved methodologies from past reviews, the investigative reports/summaries did not reconcile the relevant pieces of evidence to support the conclusions. In addition, often, sufficient methodologies were not employed. For example, review of individuals' plan, logs (e.g., behavioral data, personal care logs), and other documentation (e.g., nursing reports, training records) often was not documented as occurring. Examples of concerns have been provided in previous reports. ▪ For three (i.e., #522597, #516571, and #530098) of the five for which recommendations were warranted (60%), adequate recommendations were included. Those that did not included #513586 and #523334; and ▪ Four of 10 (40%) concluded in a timely manner (i.e., 30 days). Those that were completed timely included: #525520, #510559, #528769, and #530098. Overall, some significant progress was seen when comparing these investigations to investigations assessed as part of the Independent Expert's early reviews. Although work was still needed to refine some of the methodologies used, and particularly, to ensure a strong basis for the findings, the collaboration between DDD and DCFS and the resources that both entities were employing to improve the investigation processes appeared to be resulting in increasingly stronger investigations. In terms of the quality of the investigations, as indicated in the last report, the quality assurance functions for the DCFS now rested with the Technical Assistance Team. Since the last review, progress had been made in conducting QI Case Reviews of investigation reports. Data was presented to show reviews and some analyses of the data were occurring. Given that based on the Independent Expert's most recent review of investigation reports significant concerns continued to be the need for the use of sufficient investigation methodologies, as well as thorough analysis of evidence to form the basis for conclusions, it will be important for DCFS' QI Case Reviews to focus on these issues for individuals the Settlement Agreement covers. Based on review of the corresponding DDD surveyor complaint reports, it was clear that increased communication continued to occur between APS investigators, DDD surveyors, and CCSs than what was seen during the Independent Expert's early reviews. The most recent sample showed that often DDD surveyors had conducted independent interviews, or, as needed, onsite reviews. In one case, although APS did not confirm the allegation, DDD Surveyors cited the provider agency for regulatory issues.

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		DDD complaint reports reviewed also included information about the decisions made about the need for follow-up actions. At the time of the last review, DDD had revised the SharePoint form to make the flow more consistent with the typical complaint initiation and follow-up process, as well as to require surveyors to definitively state whether or not follow-up was needed and why. This change resulted in clear explanations of findings, as well as steps needed to resolve issues identified. These improvements, in conjunction with CCS documentation of follow-up action served to "close the loop" on issues identified through the investigation and complaint review process. In previous reports, the Independent Expert Team had expressed concerns about the definitions and criteria APS used in making decisions about which allegations would be screened out and which would be investigated. As noted in the last report, in October 2012, APS issued a document entitled: "Intake Screening Policy and Procedures Manual," with included the "Structured Decision Making System for Adult Protective Services." As has been discussed in detail in previous reports, the definition of "physical abuse" contained the phrase "resulting in physical injury." On a positive note, this had been clarified to include not only physical injury (e.g., an injury such as a fracture or a bruise), but also: "physical pain, illness, or impairment." Further guidance was given, including: "When determining if an action caused physical pain, consider whether the alleged victim gave any indication of pain (e.g., statement of pain, crying out, grimacing) and if a reasonable person would expect the action to result in pain (e.g., slapping, pushing into a wall, rough transferring)." In addition, DDD now had the opportunity to contact CFS with additional information to help clarify the seriousness of the incident, and this information could be taken into consideration when CFS determined if it met their definition for review. During this review, it appeared that some of these types of situations had been picked up for investigation. In summary, DDD and DCFS' relationship with regard to the conduct of investigations had developed over time, and at this juncture, both divisions' efforts appeared to have resulted in increased collaboration. DCFS had a process in place to notify providers of the results of investigations, and in May 2014, was initiating a process to notify providers of the need to remove alleged perpetrators from direct contact with individuals. Improvements were seen with regard to the quality of APS investigations, but this was an area that continued to require focused efforts, particularly with regard to the need for the use of sufficient methodologies and reconciliation of evidence to support the findings. DDD's complaint investigation process showed good improvement, including CCS' documentation of necessary follow-up.
B49	BSDC residents who are placed in the community shall be served by an adequate number of service coordinators to meet residents' needs. The State's service coordination program shall provide for various levels of follow-up and	*Areas in which Less Oversight is Necessary* ▪ *Generally, the State has maintained caseloads of no more than 25 individuals per Service Coordinator.* ▪ *According to data provided over the last year, many individuals have Service Coordinators with caseloads of 20 or fewer individuals.* *Areas Requiring Focused Effort*

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	intervention, including more intensive service coordination for those residents leaving BSDC with more complex needs. To encourage frequent individual contact, residents leaving BSDC will be served by service coordinators that carry a caseload of no more than 25 individuals at a time. Service coordinators involved with individuals from BSDC with more complex and intensive needs will carry a caseload of no more than 20 individuals at a time. All service coordinators shall receive appropriate and adequate supervision and competency-based training.	▪ *The State should finalize a system for assigning "intensive service coordinators" taking into consideration a number of factors, including but not limited to: 1) the risk level of the individual, which should be determined using a standardized process; and 2) the credentials and/or training/experience of the Service Coordinator. The State also will look at location, and potentially assign lower caseloads for more rural areas. (Note: This also relates to Section B50.)* ▪ *The State has provided a considerable amount of valuable training, including some competency-based training to Service Coordinators. However, at the time of the most recent review, a systematic competency-based training program covering key areas had not yet been developed/finalized. To ensure that Service Coordinators have the skills and knowledge that they need, competency-based measures should be developed and implemented in a number of areas, including, for example, the team meeting process, the drafting/development of the IPP document, service review and monitoring, and incident/allegation follow-up. Such training requirements should be systematically applied to all existing and new Service Coordinators, and Service Coordinators should be required to achieve competency with various modules within set timeframes.* ▪ *For Service Coordinators responsible for monitoring and coordinating services for individuals with complex needs, including individuals with complex behavioral/mental health needs, medical and nursing needs, as well as those with complex physical and nutritional support needs, the training requirements should ensure these staff have the necessary competencies and knowledge. It is essential that this include competencies in identifying the initial signs that an individual's condition or current status places them at potential risk, or that treatment for such a condition is inadequate.* <u>Intensive Service Coordinators</u> At the time of the review, the State was not using the term "Intensive Service Coordinators." However, it is important to note that the continued small caseloads of the CCSs assisted in ensuring that they were present frequently in the homes and day/vocational programs of the individuals on their caseloads. From their interactions with the Independent Expert Team, they clearly knew the individuals and their provider staff, and were able to speak to many of their needs and actions being taken to address them. The DDD Updates explained that the team of CCSs supporting individuals the Settlement Agreement covers was considered a targeted caseload team. In these materials, the State indicated: "The Division has found targeted caseloads helpful, because it allows the service coordinators to develop particular knowledge related to the special needs of the individuals on their caseloads – and that can positively impact the quality of supports provided… These teams support individuals with significant and unique challenges." <u>Competency-Based Training</u> As noted above, the State was in the process of modifying the IPP format and content, as well as the CCS monitoring tools. As these are finalized, training, including competency-based measures should be developed, and CCSs should be required to successfully complete the competency-based training requirements.

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		Training and Technical Assistance for CCSs on Specialized Services With regard to general healthcare, key roles for CCSs include the ability to assess overall healthcare needs, and act as an advocate to ensure the right questions are asked and all needs are being met for an individual with complex medical needs. As previously mentioned, the availability of nursing and medical clinical supports (i.e., nurses and the CMO) for CCSs to assist in ensuring that supports and services for individuals with complex medical needs were adequately provided had improved with the addition of two community nurses within the State offices. Increased presence from BSDC medical/clinical staff (e.g., psychiatry and the BSDC Medical Director) was also noted. The State had made good progress in increasing the nursing supports available to CCSs, and during this review, the Independent Expert Team observed positive impact of increased nursing and medical oversight upon the provision of care to individuals the Settlement Agreement covers. As noted above, with regard to behavior supports, there was some concern that the weaknesses noted elsewhere in this report were never identified by the CCS' monitoring. For example, items related to behavioral assessment and treatment were consistently marked "yes" (i.e., adequate) without comment, suggesting that CCSs might not have had the resources needed to detect existing problems. That being said, a number of resources were available in terms of the TBS group, and CCSs had access to training offered on behavior supports. At this juncture, determining the causes for the lack of identification of issues would be important. Training for CCSs was ongoing. In addition to New Service Coordinator Training, training opportunities were offered throughout the year. In September 2014, the "It's My Life" conference included sessions on a variety of relevant topics. Additional training, some mandatory and some not, was offered regularly. Some examples of such training included: Assuring Individual Rights: The Price of Liberty, Personal Focus Worksheet training, Compassionate Communication Training, and Urgent and Non-urgent Triggers. In addition, at regularly scheduled CCS meetings, in-service training was provided on numerous topics. In addition to the DOJ DD Community Coordinator Manager, who supervised the CCSs serving individuals the Settlement Agreement covers, the CCSs also had access to three administrators who had been assigned specific subject-matter areas for which they were responsible for developing and ensuring statewide quality and consistency. These areas included resource management, training, and operations/technology. As noted elsewhere, the QDDP Review Team also was created to support CCSs with the development of IPPs, and ongoing oversight of the implementation of IPPs. Although some specific training will need to be developed and implemented in the coming months (e.g., on the new IPP and audit formats), the State had mechanisms in place for providing training and technical assistance to CCSs.
B50	The State shall provide prompt and	*It was clear that there was a commitment to provide prompt and effective support and intervention for*

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	effective support and intervention services postplacement to residents who present adjustment problems related to the transition process such that each resident may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to: providing heightened and enhanced service coordination to the resident/home; providing professional consultation, expert assistance, training, or other technical assistance to the resident/home; providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and developing and implementing other community residential alternative solutions for the resident.	*individuals to ensure the success of transition to the community for individuals moving from BSDC. However, the system was at varying stages with regard to addressing such needs.* *Areas in which Less Oversight is Necessary* ***Short-Term or Supplemental Staffing*** ▪ *In some instances, BSDC was able to provide staffing, especially at the beginning of a transition to assist during the adjustment period.* ***Developing and Implementing Other Community Residential Alternative Solutions*** ▪ *In some instances, alternative residential solutions with the same community provider or a different on had been identified and implemented.* *Areas Requiring Focused Effort* ***Intensive Service Coordination*** ▪ *As noted above with regard to paragraph B49, all Service Coordinators had caseloads smaller than the maximum of 25 that the Settlement Agreement allows. However, it was not clear that a systematic approach had been used to assigning "intensive service coordinators" to particular individuals. For example, it did not appear that certain credentials or training requirements had been identified for Service Coordinators assigned to work with individuals with intensive behavior support needs, and/or physical and nutritional management support needs. On a positive note, the State indicated that it intended to begin using information gained through the risk identification system to assist in determining which individuals required more intensive service coordination. It will be important to the extent possible to assign Service Coordinators with expertise in these areas. A continuing challenge will be the geographical spread, and the need to have Service Coordinators available in the areas in which individuals live.* ***Professional Consultation, Expert Assistance, Training, and/or Technical Assistance*** ▪ *The details regarding the availability of training, technical assistance, consultation and expert assistance to address individuals' complex needs are discussed with regard to Section B44.* As noted in the "Areas Requiring Focused Efforts," intensive support coordination is addressed with regard to Section B49. Training, technical assistance, consultation, and expert assistance to address individuals' complex needs are addressed with regard to Section B44. The Independent Expert would recommend that these requirements continue to be addressed in these other sections of the report, and not be repeated here.
B51	The State commits to maintaining discharged residents in the most integrated community setting appropriate for their needs. Any admission or re-admission to BSDC will be considered short-term. If a	*Areas in which Less Oversight is Necessary* ▪ *Based on data the State provided, since October 19, 2007, six individuals that had been transferred in February 2009 from BSDC to hospitals or nursing homes due to their medical complexities had returned. An additional individual had been placed in the community, and then temporarily placed at Bridges until another community setting was found. This occurred quickly. One other individual had been re-admitted to BSDC temporarily, but in March 2012, was transitioned back to another*

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	resident is re-admitted to BSDC, the State shall document the basis for the readmission and then conduct a prompt assessment to identify and resolve any factors necessitating the re-admission.	*community setting. Since October 19, 2007, six individuals had been admitted to BSDC or Bridges. Since June 2009, no new admissions had occurred.*
B52	The State shall regularly collect, aggregate, and analyze data related to discharge and placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping residents in the most integrated and appropriate setting. On or before January 1, 2009, the State shall also collect, aggregate, and analyze community data for at least the past five years from its OTS program and its ITS program, which may reveal systemic problems or barriers to meeting individual consumer needs in the community. Such problems or barriers may include, but not be limited to insufficient or inadequate: housing, community resources, health care, behavior management and services, and meaningful day activities including supported employment. The State shall review this information on a regular basis and develop and implement prompt and effective strategies to overcome the problems and barriers identified.	*Areas Requiring Focused Effort* ▪ *Prior to onsite reviews, the Monitoring Team has requested information to show that the State has addressed this requirement. However, the State has provided no relevant documentation to show its efforts to "collect, aggregate, and analyze community data for at least the past five years from its OTS program and its ITS program, which may reveal systemic problems or barriers to meeting individual consumer needs in the community. Such problems or barriers may include, but not be limited to insufficient or inadequate: housing, community resources, health care, behavior management and services, and meaningful day activities including supported employment." Although, as noted elsewhere in this document, the State has addressed some of these potential barriers, the State has not presented a formal analysis. As the State develops its community quality improvement systems, it should ensure that data is collected and analyzed with regard to discharge and placement issues. During future reviews, the Independent Expert Team will request annual reports for Team Behavioral Consultation, and will speak with the Administrator for Community Based Services.* In its report for the January 2013 review, the Independent Expert Team commented on the State's efforts with regard to this provision. These findings remained essentially the same. As stated in the previous report, based on documentation provided, the State or its contractors had conducted some assessments of community data. These assessments had resulted in the identification of some potential barriers or problems to meeting individuals' needs. For example: ▪ As the State included in its DDD Updates, it developed a report entitled: "Meeting Health Support Needs of People with IDD in Nebraska Community: New Initiatives and Future Directions." The report summarized the findings from the Medical Review Team's reviews of 60 individuals the Settlement Agreement covers. Importantly, the report summarized a number of the systemic issues found as a result of these reviews. Problems identified included, but were not limited to the quality of nursing care plans, the need to better match nursing resources with individuals' health care needs, a lack of availability of integrated physical and nutritional supports, deficiencies with regard to functional behavior assessments and BSPs, insufficient behavior data collection and communication between mental health practitioners and psychiatrists, inadequate collection of data related to other health issues, and gaps in training offered to community provider staff in relation to health-related topics. It was positive that the State had utilized the information gained from these reviews to identify issues related to the provision of health care, as well as to offer some ideas about how such issues could be addressed. ▪ The State submitted TBC reports for past years, as well as the most recent TBC report from the

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		agency currently contracted to provide these supports. In addition to summarizing the work the team had done, the most recent report offered a summary of some of the barriers identified through this work, and recommendations to address some of the problems and barriers identified. ▪ As discussed elsewhere in this report, the State also was using some Therap data to identify individual trends that might show barriers or potential for service disruption. It was positive this was occurring on an individual basis. These were good examples of the State's use of data to identify barriers or problems to meeting needs in the community. As is discussed elsewhere in this report, in a number of instances, efforts were underway to address some of the systemic issues identified (e.g., offering additional training and technical assistance to providers on healthcare topics, as well as use of a contracted agency to expand capacity of providers to develop and implement Functional Behavior Assessments, and BSPs). At the time of the Independent Expert Team's review, these were in various stages of implementation. In addition, as noted with regard to Section B48, the State was still working on methods to better aggregate and analyze data for both CCS monitoring and incidents. Analysis of these data sources, as well as data related to meaningful day/vocational services could yield important information about the barriers or problems to meeting individuals' needs in the community. The State should continue its efforts to analyze existing data, as well as to address the concerns these analyses reveal.
B53	The State shall regularly review various community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State shall develop and implement effective strategies to any gaps or weaknesses or issues identified.	**DDD Oversight of Services Provided through HCB Waivers** *Areas in which Less Oversight is Necessary* ▪ *Since the Settlement Agreement was signed, DDD had taken over responsibility for review of a number of the State's HCB Waiver services. New regulations had been approved, finalized, and issued on 7/16/11. These new regulations represented a substantial revision to the regulations related to HCB Waiver Services, some of which would be licensed (i.e., homes serving four or more individuals). These regulations were the standards on which monitoring would be based. The regulations included a number of important components that, if fully implemented, should assist DHHS in ensuring that individuals who have transitioned from BSDC to the community since October 19, 2007, have the protections, supports, and services they require.* ▪ *As discussed below in the areas requiring focused effort, implementation of the regulations was in the beginning stages. However, the regulations generally set forth a reasonable process for regular "review [of] various community providers and programs to identify gaps and weaknesses… to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies." More specifically, the regulations:* ○ *Provided for certification reviews, as well as reviews to investigate complaints received or to follow up on reported incidents. Such reviews were to result in written reports being sent to the provider agency that would identify any areas found to be out of compliance with the regulations. Within 20 working/business days of receipt of the report, the provider agency*

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		was responsible for submitting a Plan of Improvement that addressed any areas cited as being in noncompliance. Responses needed to address both individual and systemic issues. Such a plan would include the action steps that had been or would be taken, the expected date(s) of completion, a means to prevent a reoccurrence, and person(s) responsible for implementation of the plan. DHHS would review and approve the plan of correction, and/or request changes. Once approved, the regulations indicated that DHHS might conduct an on-site review or request documentation to follow-up on the plan of improvement. ○ *From an administrative perspective, the regulations provided methods for DDD to effectuate change with community providers, including DDD offering recommendations, providing technical assistance, and/or requiring development and implementation of plans of correction. Should these more cooperative forms of requesting modifications to providers' system not be effective, then the regulations also provided DDD the option of imposing disciplinary actions ranging from implementation of a plan of improvement that is developed by DHHS to termination of the provider's certification. The regulations also included procedures to address an immediate and serious threat to individuals' health and safety. If implemented appropriately, these options should provide DHHS with a wide-array of actions to assist or compel providers to comply with the regulations, and to ensure that issues related to individuals' health and safety are addressed immediately.* *<u>Areas Requiring Focused Effort</u>* ▪ *Given the complex medical and physical and nutritional support needs of a number of individuals that had lived at BSDC as of October 19, 2007 who now lived in the community, including individuals currently living in a variety of HCB Waiver supported settings, as well as those that will be supported through the Medical Risk services option of the Waiver, it is essential that the survey process adequately assess whether or not they are receiving protections, services, and supports appropriate to meet their needs. Similarly, for individuals with less complex needs, but the need for day-to-day provision of health care supports and assistance with coordination of health care, the survey process, along with Service Coordinator monitoring, are key components in ensuring that providers have systems in place to adequately meet individuals' needs, and when they do not, requiring providers to develop effective strategies to address them. Similarly, for individuals with behavioral or psychiatric needs, review at both the Service Coordination and survey/certification level needs to be robust enough to identify and correct problems. Although survey and certification processes had been developed and included a number of positive components, surveyors had been hired, and surveys were being completed, at the time of the most recent review, all of the necessary components were not present to ensure adequate review of the full array of individuals' protections, supports, and services, or that problems were being appropriately uncovered. The Monitoring Team continued to identify numerous issues that neither the survey process, albeit in the initial stages of implementation, or Service Coordination reviews were identifying. Many of these issues related to*

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		the clinical aspects of individuals' support configurations. Surveyors need skills and tools to allow them to adequately assess the clinical supports and services that providers are required to provide through regulation in accordance with individuals' specific needs. The Monitoring Team has provided a number of recommendations regarding how this can be accomplished. However, these are merely recommendations, and the State might identify other options to address the issues identified. ▪ *Although a peer review process was used to assist in establishing inter-rater reliability, adequate processes were not in place to confirm inter-rater reliability or the validity of findings.* ▪ *The regulations appropriately rely heavily on individuals IPPs so that person-centered supports are provided. This means that IPPs need to include the detail necessary to allow surveyors and Service Coordinators to monitor their protections, supports, and services. In reviewing IPPs thus far, the Monitoring Team frequently has found that they do not meet this standard. This is also addressed above with regard to Section B48.* According to the DDD Updates: "The Certification/Compliance Team has eleven (11) DD Surveyor/Consultants who are located in Lincoln, Omaha, Hastings and York; and two (2) Investigators in Beatrice." As part of the document request, the Independent Expert Team requested: five certification reviews and/or reviews in which citations were made that DDD completed for agencies supporting individuals the Settlement Agreement covers, including: 1. The survey and certification report, and related correspondence; and 2. Any resulting plans of correction. These reports had been issued between September 2013 and March 2014. Based on review of these reports, surveyors were identifying some important issues related to policies and procedures, implementation of administrative requirements (e.g., background checks), staff training, as well as the implementation of services and supports. However, as noted in the last report, overall, the extent and scope of the review was not always clear from the reports, because the reports included exceptions, as opposed to providing a summary of all of the survey team's findings. In other words, the reports included citations for noncompliance with the regulations, and the evidence to support these findings. Short lists of "Agency Strengths" also were included in some reports. Although this is a typical format for many regulatory reviews, the reports did not indicate if all other areas had been reviewed and deemed to meet the regulatory requirements (although this was implied), and/or provide evidence for positive findings. As a result, it was difficult for the Independent Expert Team to determine whether or not full and adequate reviews had been completed of the variety of protections, supports, and services individuals required. As indicated in the last few reports, in reviewing monitoring protocols included in the Survey Process

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		Description and Survey Resource Guide, revised 1/10/12, based on regulatory requirements, more specific indicators were included for some areas than for others. For example, due to specific requirements in the regulations, the Core Sample Review Checklist provided some specific indicators related to BSPs, psychotropic medication, and restrictive measures. Although assessment of these requirements would still be somewhat dependent on surveyors' knowledgebase and training, as well as the technical assistance available, these indicators included some guidance. Presumably, during reviews, each of these indicators was assessed for each individual in the sample, and a lack of a finding of noncompliance in the reports meant that the provider had met the requirements. Based on the regulations, much less specificity was included with regard to other clinical areas, such as medical, nursing, and PNM issues. As a result, it remained unclear to the Independent Expert Team what methodologies the surveyors were using to determine compliance with broader requirements such as: "Unless otherwise identified in the IPP, the agency takes reasonable steps to assist and support individuals in obtaining health services consistent with his/her needs," or "The agency ensures health status and physical conditions are observed, reported, and responded to in a timely and appropriate manner as needed." As noted with regard to Section B48, although plans to improve IPPs were beginning to be implemented through a pilot project that did not involve individuals the Settlement Agreement covers, IPPs were not yet adequate, and did not comprehensively identify individuals' needs for protections, supports, and services. As a result, surveyors could not yet rely upon them to define these health care components. Without adequate IPPs and/or further guidance regarding the methodologies used (e.g., documents reviewed, interviews conducted, standards employed, etc.) and more detailed indicators, it was not clear how surveyors were determining that providers were appropriately meeting individuals healthcare and therapeutic needs, and/or identifying all of the circumstances in which they needed further technical assistance. Previously, the Independent Expert Team had recommended establishing inter-rater reliability, and this was included as an "Area Requiring Focused Effort." At the time of the last review, it was hoped that with input from the State's consultant, the State would determine and implement the best way to ensure the results from surveys are reliable and valid. Based on interview during this review, staff indicated the consultant's report was not helpful in this regard. Although not formal methods for establishing inter-rater reliability, State staff continued to indicate that peer review of reports, and supervisory review assisted in ensuring inter-rater reliability. The survey and certification process was generating reports that required, at times, more extensive plans of correction from providers. According to staff, an area of focus was on working with providers to improve their plans of correction to ensure they addressed the concerns identified. Based on the Independent Expert Team's review of the sample of reports, the corrective action plans providers submitted and DDD approved generally addressed the concerns identified in the reports to correct the specific deficiency, but also on a systemic level. This was an important requirement included in each cover letter DDD sent with the reports. At times, DDD clearly worked with providers to ensure strong

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		plans of correction were in place (e.g., certification report dated 12/20/13). The QI Committee had begun to review data related to citations from certification/ compliance reviews. Next steps included in-depth analysis and follow-up to trends identified. The Independent Expert Team continues to recommend: ▪ Individuals' IPPs should include the detail necessary to allow surveyors and Service Coordinators to monitor their protections, supports, and services based on the IPP provisions of the regulations found in Section 4-005.01A-C; and ▪ The survey/monitoring tools used should include sufficient indicators and the survey/monitoring methodologies should be adequate to ensure individuals are provided the protections, supports, and services they require, and to which they are entitled pursuant to the Settlement Agreement. Similar to what State Office staff had begun to do for CCSs, the State should develop specific tools to review in more depth the provision of supports and services, particularly for areas in which individuals could be at risk (e.g., healthcare, PNM, behavioral, etc.), if adequate supports are not provided. **Division of Public Health Oversight of ICFs/ID and Nursing facilities** *Areas Requiring Focused Effort* ▪ *Given the complex medical and physical and nutritional support needs of a number of individuals that had lived at BSDC as of October 19, 2007 who now lived in the community, including individuals currently living in ICFs/ID as well as nursing homes, it is essential that the survey process adequately assess whether or not they are receiving protections, services, and supports appropriate to meet their needs. Similarly, for individuals with less complex needs, but the need for day-to-day provision of health care supports and assistance with coordination of health care, the survey process is key to ensuring that providers have systems in place to adequately meet individuals' needs, and when they do not, requiring providers to develop effective strategies to address them. Similarly, for individuals with behavioral or psychiatric needs, review at both the survey/certification level needs to be robust enough to identify and correct problems. During the most recent review, no survey and certification reports were provided for review. However, based on past reviews, issues that the Monitoring Team identified (e.g., lack of adequate nursing plans, missing or inadequate physical and nutritional supports, lack of appropriate behavioral supports for individuals who needed them, etc.) were not adequately reflected in the survey reports. Although the Monitoring Team appreciates the Division of Public Health's statutory authority, and role in the licensure and certification process of both nursing home and ICFs/ID, in order for the requirements of the Settlement Agreement to be achieved, a comprehensive and enforceable system needs to be in place to ensure that gaps and weaknesses for all of the various provider types are identified and addressed.* ▪ *As discussed during previous onsite reviews, this likely will require coordination between the various DHHS divisions. It will be important to identify areas in which collaboration might be necessary or*

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		beneficial to achieve this goal, while taking into consideration the role of the various divisions, including their authority, the scope of what they review, and the expertise, qualifications, and training of staff. Based on the Independent Expert Team's monitoring reviews over time, ICFs/ID that supported individuals the Settlement Agreement covers had become more responsive to the Division of Developmental Disabilities' recommendations and requests as compared to when the Independent Expert first started conducting reviews. Examples were provided in previous reports. Ultimately, the Settlement Agreement requires the State to ensure individuals are provided the protections, supports, and services they require. Although not all issues with individuals supported in ICFs/ID had been resolved, given DDD's improving ability to influence the services ICFs/ID provided to individuals the Settlement Agreement covers, the Independent Expert chose during this and the previous review to focus less on the Division of Public Health's survey and certification role.

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

SECTION C: Training and Behavioral Services, Restraints (C54 through C80)

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents:**
  - Record reviews for: Individual #183, Individual #326, Individual #91, Individual #62, and Individual #352;
  - Current BSP for: Individual #237, Individual #350, Individual #366, Individual #82, Individual #203, Individual #62, and Individual #94;
  - Current IPP for Individual #251, Individual #192, Individual #277, Individual #268, and Individual #55;
  - Formal Habilitation Program template, dated 3/13/14;
  - Formal Habilitation Program Checklist, dated 3/12/14;
  - IDT Meeting Process Checklist with and without instructions;
  - Individual Program Plan Checklist with and without instructions;
  - Personal Focus Worksheet template;
  - Pre-IDT Collaboration Flow Chart, dated April 2013;
  - Policy 4.2 Individual Program Plans;
  - IPP Checklist, dated 9/30/13, with and without directions;
  - Policy 4.3 Plan Coordination, Oversight and Modification;
  - Guidelines for Writing Objectives;
  - Guideline: Quality Assurance/Improvement Process Monitoring of QDDP Documentation, dated 2/27/14;
  - Fading Process for Review of QDDP Documentation, dated 2/27/14;
  - QDDP Coordinator – Departmental Indicator Summary report for 4th Quarter, 2013;
  - Annual IPP Review Process Flowchart, dated 2/27/14;
  - Quarterly Review Process Flowchart, dated 2/27/14;
  - Draft Guideline: Development of Individualized Program Plan, dated 3/13/14;
  - Draft Guideline: Development of IPP Checklist, dated 3/13/14;
  - Draft Guideline: Habilitation Plan Monthly Progress Report, dated 3/13/14;
  - Assessment Needs Checklist for Annual Individual Plan, dated 4/3/13;
  - Draft Monthly Progress Report Checklist, dated 3/13/14;
  - Treatment Integrity Process, dated 3/13/14;
  - Policy 5.1 Behavior Supports, dated 9/18/12;
  - Facility QI Report – 3rd Quarter 2013 and 4th Quarter 2013;
  - Individual Program Plan template with hints;
  - Quarterly IDT Meeting template with hints;
  - Quarterly Review Checklist with and without directions;
  - BSP Progress Note Peer Reviews for the past six months;
  - BSDC BST Orientation Manual and Reference – 2014;
  - List of Behavioral Priority individuals;
  - Psychological Evaluation Peer Reviews;
  - BSP Procedure and Competency checks/Treatment Integrity checks (past six months) for the following homes:
    - 402 State
    - 404 State

        - 406 State
        - 408 State
        - 411 State
        - 412 State
        - 413 State
        - 414 Sheridan
        - 415 Sheridan
        - 416 Sheridan
        - 418 Solar
        - 420 Solar
        - 422 Solar
        - 424 Solar
        - 311 Lake Street
    - List of Psychology/Behavior "Tools" Used for Assessment;
    - BSP Ongoing Tracking list;
    - List of Persons Receiving Psychotherapy;
    - Behavior Support Team personnel list;
    - Minutes from Behavior Support Review Committee (BSRC), for the last six months;
    - Most recent psychological evaluation spreadsheet printout;
    - List of Persons Who Had Functional Behavioral Assessments in Past Year;
    - List of individuals in each Behavioral Needs Group and description of Behavioral Needs Group identification process;
    - Description of on/off campus work sites and number of individuals employed at each site;
    - Work and Volunteer Hours – April 2013 through February 2014;
    - Community Outings reports;
    - Human Legal Rights Committee (HLRC) minutes, from August 2013 through February 2014;
    - Restraint log – past 12 months;
    - List of individuals receiving emergency psychotropic medication – past 12 months;
    - List of instances of use of medical restraint;
    - Documentation of review/debriefing for the last five restraints;
    - List of injuries incurred during use of restraint – past 12 months;
    - List of individuals with three restraints in 30 days for whom an IDT meeting was held as a result;
    - QDDP Coordinator – Status Update;
    - QDDP Support Services – QI Team Description;
    - Updated IPP template and Checklists;
    - Dr. Sorrell's notes from the last three months of psychiatry/neurology/primary care joint clinics;
    - Sign-in sheets for community FBA Training sessions provided by BSDC Behavior Support Team (BST) personnel;
    - Draft Documentation Guidelines;
    - Diagnosis Review Meeting notes for the past six months;
    - BSP Data Sheet (Individual #401);
    - Medication Provision for Behavioral Crisis Intervention and Informed Consent Tracking algorithm;
    - One-time medication use notes for the last six months;
    - Socialization program (Individual #366); and

- HLRC Medical Checklist.

- **Interviews with:**
  - Management Team (Introductory overview);
  - Dr. Shawn Bryant, Director, Behavior Support Team;
  - Dr. Todd Stull, Medical Director;
  - ICF Administrators;
  - Alicia Stevens, Qualified Developmental Disabilities Professional Coordinator;
  - Kathy Whitmore, HLRC Chair;
  - Angie Ludemann, DOJ Transition Manager; and
  - Vocational and recreational services team.
- **Observation of:**
  - Home Rooms – D Building, Bear Creek Shop and Art Studio, and private provider's day program site.

SECTION C: Training and Behavioral Services, and Restraints (C54 through C80)		
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Training and Behavioral Services		
Principal Requirement		
C54	The State shall provide adequate psychological and behavioral services, including skills training and positive behavioral support plans, to meet the individualized needs of each resident, especially those with challenging behaviors. These services shall be developed and implemented to ensure and protect residents' right to training sufficient to provide each resident a reasonable opportunity to enhance functioning, to grow and develop, to attain self-help and social skills needed to exercise as much autonomy or independence as possible, to prevent or decelerate both physical and psychological regression, loss of skills and functional status, and to ensure their reasonable safety, security and freedom from undue	*As the principal requirement, adequate implementation of this section is dependent upon the State addressing Sections C55 through C71.*

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	bodily restraint. To this end:	
Individualized Assessments		
C55	The State has begun and will continue the process of conducting a new interdisciplinary evaluation of each resident to determine the specific areas in which each resident needs training. These interdisciplinary evaluations shall be completed for all residents on or before January 1, 2009, and shall be repeated for all residents at annual intervals, unless required more frequently by each resident's needs; residents with challenging behaviors will likely require interdisciplinary evaluations much more frequently than once a year.	*The various components of the interdisciplinary evaluation are addressed in the following sections: C56 – behavior assessments; C83 – psychiatric evaluations; D92 – healthcare evaluations; D100 – neurology evaluations; D111 nursing assessments; D123 – physical, nutritional management assessments; D131 – Occupational Therapy (OT), Physical Therapy (PT), Speech Language (SL), assistive technology, and physical assistance supports assessments; D132 – assessment of individuals who use mobility, alternative therapeutic positioning, or other assistive technology supports; and D140 – SL, including augmentative and alternative communication (AAC).* *Areas Requiring Focused Effort* ▪ *The Individual Program Plans Policy #4.2, implemented 8/27/11, did not require at least annual repeat of the interdisciplinary evaluations, as required by the Settlement Agreement, or define how decisions would be made about when individualized assessments should be conducted. The policy stated: "Comprehensive Functional Assessments are completed if not available or reviewed upon admission to an ICF on the BSDC campus and updated as needed to remain current and accurate to address areas of need..." Based on the parties' discussion, for medical assessments/evaluations, the History and Physical should define when individual assessments/evaluations are necessary. A listing of potential evaluations is included on the template. Reasons should be provided if an assessment does not need to be done at the standard frequency. IPPs should identify other assessments the individual requires. The IPP template lists the assessments, and if one is not being done, then the team should provide the reason or justification.* As noted in the Independent Expert Team's previous report, the revised Individual Program Plans (IPP) Policy #4.2, effective 8/13/12, stated: "… it is the policy of BSDC that such [Individual Program] plans, including all assessments are developed, reviewed and updated at least annually…" This would appear to bring the policy into accord with the Settlement Agreement. In addition, the Facility had instituted an Assessment Needs Checklist to be completed by the IDT "at the 3rd Quarterly Review" that indicated: "which assessments are to be completed or reviewed and updated." A prompt regarding the completion of the checklist was included in the template for the Annual IPP meeting and the template for the Quarterly IDT Meeting. Based on IPPs reviewed for the present review, BSDC practice appeared to be generally in accord with the requirement for annual assessments.
C56	This interdisciplinary evaluation shall include adequate behavioral assessments (including an individualized, formal functional analysis whenever appropriate)	*Areas in which Less Oversight is Necessary* ▪ *The components the Settlement Agreement required that were present in the newer functional assessments were:* ○ *A description of the behaviors(s);* ○ *The collection of empirical data;*

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	based on the input from the psychologists and an interdisciplinary team. A functional analysis is an assessment of an individual's behavior that includes: (1) a description of the behaviors(s); (2) the collection of empirical data; (3) an assessment of the behavioral intensity, frequency, duration, and severity; (4) an evaluation of the antecedents, consequences and function of the behavior(s); (5) an assessment of any medical, nursing, mental health or other conditions related to the behavior(s) so as to determine the medical, behavioral, mental health, environmental and/or other factors that may be causing each resident's challenging behaviors; and (6) the development of skills training, behavior support, and other procedures based upon the analysis. The psychologist's assessment and functional analysis shall be based on a first-hand, in-depth, observational analysis of each resident's behavior, and not primarily from data provided pursuant to a screening tool.	○ *An assessment of the behavioral intensity, frequency, duration, and severity; and* ○ *An evaluation of the antecedents, consequences and function of the behavior(s).* *Areas Requiring Focused Effort* ▪ *With respect to the specific components the Settlement Agreement required, functional assessments were lacking with respect to:* ○ *An assessment of any medical, nursing, mental health or other conditions related to the behavior(s). While a "Medical Information" section generally was included, the content often failed to integrate medical and psychiatric information into the overall understanding of the challenging behaviors;* ○ *The development of skills training, behavior support, and other procedures based upon the analysis. The functional analysis and the resulting BSP often failed to include appropriate, active skills training interventions targeting the identified replacement behavior; and* ○ *"The psychologist's assessment and functional analysis shall be based on a first-hand, in-depth, observational analysis of each resident's behavior…" It was not always apparent that the functional assessment included direct observation.* Behavior Assessment Reports (BARs) provided for review during this review typically included a summary of medical conditions that were potentially relevant in understanding target behaviors. Behavior Support Plans (BSPs) provided for review during this review routinely included some form of active skills training aimed at developing and/or strengthening replacement behaviors. In some cases, the intervention consisted of prompting and reinforcement (without planned instruction or rehearsal). In such cases, the peer review process might encourage the development of more active instruction components. BARs provided for review during this review consistently documented direct observation as one of the components of the functional behavior assessment. Thus, the sample of BARs and BSPs provided for review generally included the components of the functional behavior assessment identified as requiring focused effort. Specifically, all BARs included a section devoted to "an assessment of any medical, nursing, mental health or other conditions related to the behavior(s)"; and all BARs included documentation of "a first-hand, in-depth, observational analysis of each resident's behavior…" The ongoing peer review process might reasonably be expected to continue to identify and address remaining quality issues. Psychologists reportedly were conducting regular peer reviews of Psychological Evaluation reports. Examples provided to the Monitoring Team for review suggested that the process was undertaken with integrity and should support continued quality improvement. The 4th Quarter QI report from the peer

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		review process for Psychological Evaluations indicated that three of the five components were below the compliance target. The 4th Quarter QI report from the peer review process for Behavior Support Team Progress Notes indicated that "Analysis" was the weakest component of the progress notes. Other components showed above 90% compliance. In summary, the practice of functional behavior assessment at BSDC appeared to be generally in line with expectations described in the Settlement Agreement.
Skills Training and Habilitation		
C57	Based on this evaluation, the State shall develop and implement a professionally-based, individualized skills training and habilitation support plan for each resident and provide each resident with a minimum of five hours per day of off-residence skills training, in the community whenever appropriate, derived from the resident's skills training and habilitation support plan, to meet the individualized needs of each resident. The skills training and habilitation support plans shall include real-life variables, in the community whenever appropriate, with outcome measures that will be meaningful to residents with an emphasis on providing training in functional contexts. Plans shall be developed and implemented with a focus on proactive skills building and an emphasis on reducing the use of restrictive interventions. Residents' needs for meaningful training shall be continually met.	*Areas Requiring Focused Effort* ▪ *Policy: The revised Individual Program Plan policy (#4.2, effective 8/27/11) described the contents of the IPP and the process by which it is developed. However, it did not include a requirement for "five hours per day of off-residence skills training," nor did it emphasize training "in the community." A further revision of this policy was reportedly under review.* The Individual Program Plan Policy #4.2, effective 8/13/12, was unchanged and thus, as previously noted, did not include a requirement for "five hours per day of off-residence skills training," or justification if this was not appropriate for an individual, nor did it emphasize training "in the community." However, as noted elsewhere in this report, the Facility was tracking individuals' time engaged in structured activities. Further, the current IPP [peer review] Checklist guided raters to indicate whether there was "documentation that individual spends at least 5 hours off home skills training and community integration" Thus, the Quality Improvement processes in place might reasonably be expected to sustain incremental improvement in practice with respect to this provision. ▪ *Practice: At the time of the January 2012 onsite review, a revised template for the IPP reflected continued evolution and appeared generally adequate to guide the creation of an appropriate IPP. However, it had only been piloted with one individual. Areas in which Individual Program Plans (IPPs) required improvement included:* o *The goals and objectives needed to reflect the individual's choices/preferences, with connections made between the individual's choices/preferences and the Need/Goal/Objectives" section of the IPP.* The current IPP Checklist guided raters to indicate whether there was "at least one goal/objective

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		identified that is specifically building upon a specific interest/desire/hope/dream." For each Goal on the IPP, the template guided staff to consider whether the goal "reflects individual interests/desires or hopes/dreams." The 4th Quarter 2013 QI report provided data, based on peer review, as to whether the IPP under review had "formal goals that either: 1) reflected the individual's choices and preferences; or 2) were developed based on knowledge of the individual's interests, desires, hopes, and dreams. 100 percent of the IPPs reviewed (n=22) were judged compliant with the indicator, and this was the fifth consecutive quarter with 100 percent compliance. A related QI indicator was: "there is at least 1 goal that reflects the individual's desires and interests with a specific connection to desires and interests." Campus-wide, 95% of IPPs (21 of 22) met this indicator in the 4th quarter of 2013. A review of recently completed IPPs supported the conclusion that they generally included at least one goal and objective that could be identified as associated with things that were important to the individual. Facility staff described continued positive developments in the planning process and in the IPP documents. Two Program Specialist positions were added to create the QDDP Support Services Team in an ongoing effort to continue improvement of BSDC IPPs. Staff provided documentation of a well-developed quality improvement process applied to the development of IPPs, including evidence of good inter-rater reliability with respect to the assessment of compliance with IPP guidelines. The quality of IPPs had shown good improvement and the QI process, if maintained, appeared to be adequate to sustain that improvement. ○ *The transition sections of the IPPs needed to consistently provide meaningful consideration of the individual's needs were he/she to transition outside of BSDC.* ○ *Teams needed to consistently use data in the IPP development process to make decisions regarding continuation or discontinuation of programs and plans.* A review of recently completed IPPs indicated that judgments about progress generally appeared to be consistent with the data reported, and that such judgments generally led to justifiable decisions regarding termination, revision, or continuation. ○ *Teams needed to consistently address recommendations included in the annual assessments by either incorporating them into the individual's "Need/Goal/Objectives," or*

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		providing a justification for not including them. The Individual Program Plan Checklist included the item: "… recommendations noted and plans to address" with respect to Medical, Dental, Therapies, and Day Services, and Employment, Recreational Involvement, and Behavioral Needs. A review of recently completed IPPs indicated that recommendations from the assessments were generally reflected in individuals' goals. One exception was: • For Individual #55, two recommended Occupational Therapy goals ("drive the power wheelchair safely" and "Upper extremity active range of motion will increase") and an apparent Physical Therapy goal (skilled physical therapy to work on hip flexion) were not included in the Formal Goals section of the IPP. o *IPPs needed to include the most up-to-date and accurate diagnoses.* The Individual Program Plan Checklist included the item: "Diagnosis matches Psychiatric diagnosis." A review of recently completed IPPs indicated that all reported diagnoses were consistent with psychological/psychiatric reports. o *Communication goals in the IPPs required improvement, which was heavily related to the need to improve communication assessments (addressed with regard to Section D140).* A review of recently completed IPPs indicated that they generally included communication goals, representing a significant improvement compared to earlier practice. The 4th quarter (2014) QI report indicated that 93% of individuals who needed functional and/or Language Communication assistance received such assistance. This was the third consecutive quarter for which the indicator fell below the target (100%). There may be reason to believe that these data reflect increased sensitivity on the part of Facility staff to the communication needs of the individuals they serve and increased awareness of the options for supporting individuals through functional communication assistance. In any case, the data suggested a continued need for vigilance with respect to communication needs. o *IPPs needed to consistently document an adequate habilitation/skills training program.* As noted previously, the Individual Program Plan Checklist included the item: "Documentation that individual spends at least 5 hours off home skills training (if not justification for not [sic] is provided," and the item: "Documentation that the individual schedule provides activities that are reflective of and

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		build upon their interests/desires, hopes/dreams and provides opportunities for community activities and more inclusive living." Thus, the Quality Improvement processes in place might be reasonably expected to support incremental improvement in practice with respect to "an adequate habilitation/skills training program." A review of recently completed IPPs indicated that they generally included an appropriate number of formal programs, covered a range of areas of need, and represented reasonable effort to address training in areas associated with what was important to the individual. A revised description of the process for monitoring treatment integrity for formal habilitation programs was provided for review. The process appeared to be well established within the practice of the Facility and adequate to address the goal of ensuring treatment integrity. ○ *Baseline data needed to be clearly established for all new programs.* The revised IPP Template included a prompt to include baseline information for any new objectives in the IPP and the Checklist included this expectation as well ("Baseline data provided for NEW objectives"). ○ *The Facility recognized the need to modify its Safety Plan, and had begun using a Crisis Intervention Plan. At the time of the review, a plan needed to be developed and implemented for how and where all safety-related information for an individual would be maintained.* The revised IPP template had clarified where the Safety Plan/Mental Health Behavioral Crisis Intervention Plan was to be kept in the individual's record, if such a plan existed. Overall, IPPs continued to show incremental improvement. IPP audits appeared likely to sustain the progress and the process seemed likely to yield IPPs that were generally in accord with expectations of the Settlement Agreement. ▪ *Practice: Efforts were underway to document "a minimum of five hours per day of off-residence skills training" for all individuals. However, the system was not fully implemented, and systematic documentation of the amount of skills training/habilitation individuals received still was not available. It will be important to provide a link between individuals' IPP goals and the attendance/participation data generated.* The 4th Quarter (2013) Quality Improvement Report indicated that, campus-wide, 83% of individuals had "5 or more hours of active treatment per day." The 4th quarter result was somewhat lower than that

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		for the 3rd quarter (91%), but approximated the mean for the year. An action plan indicated: "The liaisons will communicate with the QDDP for all individuals who have not met the 5 hours off-residence training for the week, document the reason why, and develop an improvement plan appropriate for the circumstances." The data suggested that the Therap system for tracking individuals' training and activity time was working and was providing meaningful information about individuals' programs. It appeared that it was not yet possible to provide a clear link between individuals' IPP goals and the activity data generated by the tracking system, nor did it appear that this was on the agenda with respect to the evolution of the system. However, the QI system included an Audit of Home Rooms to measure "the number of individuals whose day program activities in their respective Home Rooms and at the Activity Center match indicated likes and needs in their IPP, as well as their skill levels." Fourth quarter 2013 data for this indicator showed a 93% compliance rate. ▪ *Practice: In the fourth quarter of 2011, 36 individuals worked off campus (three of these only worked off campus) and 91 worked on campus. Efforts had been made and were continuing to expand work opportunities. The total average hours worked per person was 5.65. Although a number of efforts were underway to increase opportunities available to individuals, defining individuals' preferences, strengths, and needs with regard to vocational services, and developing action plans to meet identified goals was an area requiring continued improvement.* During 2013, the number of employable individuals employed in the community remained relatively steady (ranging from 51 to 58 across the four quarters). This represented growth, compared to previous years. The number of individuals "not working but employable" was seven in the 4th quarter of 2013 (compared to 13, four, and seven for the previous quarters). In the 4th quarter of 2013, 92% of employable individuals worked or volunteered five or more hours per week, compared to 63%, 76%, and 89% in previous quarters. These data provided some evidence that efforts to increase vocational opportunities for individuals have yielded positive results.
C58	In developing and implementing the skills training and habilitation support plans, the State shall provide residents with these services in the most integrated setting appropriate for each individual resident. The State shall emphasize involvement in and with the community, away from the	*This is closely related to and could be combined with Section C57.* *Areas Requiring Focused Effort* ▪ *There was a need to continue to develop day programming, volunteer, residential/adaptive living skills, and recreational opportunities in more integrated settings for more individuals served by the Facility. In addition, to assist in ensuring that individuals are appropriately afforded such opportunities, more IPPs should identify goals and objectives to be implemented in community settings.*

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	BSDC campus, as much as possible and appropriate, according to each resident's individualized needs.	In an effort to foster transition to integrated residential settings, the Facility had increased the capacity of the on-campus apartments and separated the apartment program as an independent ICF. External consultation had been provided to make the apartments more focused on developing independent living skills. Staff reported that efforts also were undertaken to foster generalization of skills taught in habilitation programs by means of in-service training for QDDPs, additional prompts and examples in the IPP template, and collaboration with clinical services. Staff noted that instructions regarding the collection of data in the community were incorporated into the IPP Template and Habilitation Plan outline. The IPP Checklist guided raters to indicate whether there were "opportunities for training in a variety of settings, including training in day services and the community." For each Goal on the IPP, the template guided staff to consider whether the goal can be "trained away from BSDC campus;" and "What generalization or integration is there between Habilitation and other areas such as therapies, nursing outcomes, daily activities." Staff reported that training regarding the Habilitation Plan schedule of data collection for an intervention program emphasized including the number or percentage of probes that were to be conducted in a community setting. Observation during the review indicated that, with respect to vocational/day service opportunities: ▪ A community-based provider was serving and increased number of individuals living at BSDC (n=37), and was in the process of adding a new vocational services space with the hope of adding capacity for 20 more individuals. ▪ The list of "day and work program sites" provided in response to Document Request V.15 included 22 on-campus opportunities; eight of these were volunteer-only. There were 34 off-campus sites of which 13 were volunteer-only. ▪ Staff reported that additional vocational support persons were being hired and that position descriptions had been revised to allow them to follow individuals into community-based vocational placements. A total of ten staff persons had been designated as job coaches. ▪ The Facility had scheduled an external consultant to provide training in vocational preparation, job development and linkage to the community for vocational program staff. ▪ Two new community-based employment opportunities had been developed. ▪ The on-campus Bear Creek operation reportedly offered employment opportunity to more individuals (n=22) and was sufficiently staffed such that direct support personnel from the residences did not need to remain with individuals while they were working. Sales at Bear Creek were noted to have doubled.

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		▪ Staff reported that 66 of the 91 non-retired individuals at BSDC participated in community-based employment at some level. ▪ Data in 4th quarter QI report indicated that, for 2013, 62% of individuals eligible for employment were "employed in the community." This compared favorably with data from previous years (2012 – 35%; 2011 – 24%; 2010 – 7%). In sum, the Facility continued to develop day support and employment programming, volunteer opportunities, residential/adaptive living skills training, and recreational opportunities in more integrated settings and more IPPs identified goals and objectives for implementation in community settings. The Independent Expert Team recommends that the parties consider this as an area in which less oversight is necessary.
C59	The State shall develop and implement an initiative to significantly increase community integration activities and opportunities for residents day-to-day, including: (a) community supported employment; (b) community day programming; (c) community volunteer activities; and (d) community business and recreational outings, including but not limited to grocery stores, pharmacies, restaurants, theaters, and places of religious expression. This initiative shall ensure that staffing, transportation, and other resources are adequate to meet the residents' needs for community integration activities and opportunities.	*Areas in which Less Oversight is Necessary* ▪ *Although an area in which continued vigilance was needed to maintain progress made, transportation and/or staffing issues did not appear to be a barrier to community integration activities.* *Areas Requiring Focused Effort* ▪ *Some of the ICFs/ID had begun collecting baseline information on community integration activities. However, based on data submitted, the Facility was at the beginning stages of collecting and analyzing both quantitative and qualitative data in this area.* The 4th Quarter QI report indicated that all ICFs showed an increase, for the year 2013, in the percent of individuals involved in at least one activity per week in an integrated, off-campus activity. In the 4th quarter, 92% of individuals were so involved.
C60	The State shall develop and implement an initiative to better engage residents in meaningful training and activity throughout each day, according to their	*Areas in which Less Oversight is Necessary* ▪ *During the most recent review, staff reported significant changes with respect to the use of the Carstens Center, including: more individuals present in the building; more areas being used, more of the time (e.g., increased use of the gym); more homes coming to use the kitchen and gym for home-initiated activities; additional lifeguard availability to make the pool more accessible; and*

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	individualized needs, when the residents are on-campus and/or on their living units. This initiative shall make better use of on-campus recreational facilities, such as at the Carstens Center.	*opening the building for community use. Appropriately, the focus is on increasing participation in the community as opposed to more use of the Carstens Center.* Although this was an area requiring less oversight, it is worth noting that further renovations to Carstens Center had served to increase program space by consolidating staff areas. An upgraded workout room had been opened for individuals and staff to use. Also, the Facility had conducted upgrades to the Activity Center program for individuals who were "retired" allowing some of them to eat lunch at the Center and creating the possibility for individuals to participate in lunch preparation in the future. Further planned renovation included creating a quiet area, and a rest area (for those needing to nap during the day). It was reported that, when the Activity Center was fully staffed, direct support persons from the residences would no longer remain with individuals at the Center throughout the day. *Areas Requiring Focused Effort* ▪ *During the onsite review, observations in day/vocational settings suggested some gains in achieving engagement of individuals in activities. Continued work was needed on making those activities functional, appropriate, and meaningful to the individuals. The Facility's own monitoring activities identified similar concerns, and at the time of the [January] 2012 onsite review, a plan had been initiated to make improvements.* Staff reported further efforts to match Home Room activities to individuals' interests and IPP goals. Further, at least informally, there appeared to be a conceptual shift regarding the role of the Home Rooms, de-emphasizing them as primary habilitation sites in favor of community-based vocational and other opportunities. This shift appeared to be consistent with the intent of the Settlement Agreement. Facility staff are encouraged to continue seeking to ensure that individuals' time spent in Home Rooms (while appropriately diminished due to increased community activities) is constructive and consistent with interests and goals identified in individuals' IPPs. A QI indicator was established in 2013 tracking the "number of individuals whose day program activities in their respective Home Rooms and at the Activity Center match indicated likes and needs in their IPP, as well as their skill levels." Fourth Quarter 2013 data indicated 93% compliance with the indicator, compared to 100% in the three previous quarters. Based on observation in the Home Rooms, there is some reason to suspect that the data collected for this indicator might not accurately reflect the actual experience of individuals in the Home Rooms, and the Facility is encouraged to continue development of the indicator to ensure that it is valid and sensitive to individual variation. The tracking system for individuals' vocational, recreational, and habilitation time was reportedly functioning within Therap and involved documentation of activities every 30 minutes. Staff reported

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		that in the previous week, only two individuals had fallen short of the goal of five hours per day. As noted earlier, QI data for the 4th quarter 2013 indicated that 83% of individuals had at least five hours per day of off-residence skills training. This was down slightly from the previous two quarters (88% and 91%). An action plan was developed.
Positive Behavioral Support Plans		
C61	For residents with behaviors, the State shall ensure that psychologists develop and implement positive behavioral support plans that include: (1) a detailed definition and identification of the specific, measurable, and objective behavior(s) to increase and/or decrease; (2) a description and incorporation of the individualized functional analysis; (3) a comprehensive discussion of how medical and/or psychiatric disorders impact behavioral problems; (4) the procedures for staff to follow to decrease the occurrence of the problem behaviors; (5) the skills and positive, adaptive behaviors (to include replacement behaviors) that will be taught and the procedures for teaching them; (6) environmental changes to promote the development of positive, adaptive behaviors; (7) individualized reinforcers and/or preferences as determined in accordance with the needs of each resident; (8) an individualized schedule of active treatment activities as documented in the	*Areas Requiring Focused Effort* ▪ *Although BSDC had improved its BSP template to address most of the requirements of the Settlement Agreement (i.e., did not include a section on environmental changes to promote the development of positive, adaptive behaviors), based on documentation the Facility provided for the January 2012 review, only 18% of the 97 BSPs had been finalized, approved, and "training done." In addition, review of BSPs continued to find issues related to their quality (e.g., inadequate descriptions of data collection systems; failure to identify appropriate specific, individualized behaviors as replacement behaviors; failure to include an appropriate active teaching procedure for replacement behaviors; discrepancies in the description of restrictive interventions; lack of adequate definition of specific, measureable, objective "Positive Behaviors to Support;" failure to incorporate individualized functional assessment identifying a hypothesized function for the behavior; and lack of collaboration between speech/language pathologists and behavior analysts with respect to BSP development, as appropriate). This section of the Settlement Agreement requires "that psychologists **develop and implement** positive behavior support plans" (emphasis added) that include the list of required elements."* Behavior Assessment Reports and Behavior Support Plans provided in response to document requests were reviewed. For each of the required components listed below, the Plans that the Independent Expert Team reviewed were judged to be adequate: 1) Definition and identification of the specific, measurable, and objective behavior(s) to increase and/or decrease; 2) A description and incorporation of the individualized functional assessment; 3) A comprehensive discussion of how medical and/or psychiatric disorders impact behavioral problems; 4) The procedures for staff to follow to decrease the occurrence of the problem behaviors; 5) The skills and positive, adaptive behaviors (to include replacement behaviors) that will be taught and the procedures for teaching them; 6) Environmental changes to promote the development of positive, adaptive behaviors; 7) Individualized reinforcers and/or preferences as determined in accordance with the needs of each resident; and 9) An adequate data collection system.

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	resident's individualized plan that corresponds to the resident's treatment needs; and (9) an adequate data collection system that includes appropriate data collection procedures which, for residents with positive behavioral support plans, shall measure information about maladaptive and adaptive behaviors and the conditions under which they occur, including, where appropriate, the frequency, intensity, severity, and duration of the behaviors.	With respect to: "(8) an individualized schedule of active treatment activities as documented in the resident's individualized plan that corresponds to the resident's treatment needs," behavior plans did not include schedules of activities. However, it was observed that individuals' schedules were routinely located in their program books. As a result, BSDC was considered to have addressed the spirit of this requirement. In light of the above, the peer review process for BSPs appeared to be functioning adequately and producing positive changes in the quality of recently developed BSPs. As noted in the previous report, an initiative that appeared to be well established and that significantly improved the integration of behavioral services was the decision to tie Behavioral Support Team personnel more closely to specific ICFs and homes. This change, initiated by the BST, appeared to have had significant positive impact on the system as a whole and supported improvements in behavioral services. ▪ *Although improvements had occurred, ensuring timely implementation of revised plans continued to need improvement.* In most cases, based on data made available in response to Document Request V.6, plans appeared to be implemented within a reasonable period of time following the review and approval process. One notable exception was: ▪ The BSP for Individual #183 was said to have received BSRC approval on 12/8/11 and IDT approval on 1/9/12. It did not receive HLRC review and no Addenda or Revisions were noted. However, it implementation occurred on 3/14/14. If these data were correct, they documented a concerning delay in implementation of 26 months. If instead, as seemed likely, this represented an error with regard to data entry into the tracking system, it should be corrected. Those responsible for monitoring the tracking data should ensure such delays do not occur and/or that such errors are not allowed to persist within the system. Finally, in response to Document Request V.13, a new BSP for this individual (written on 2/25/14) was provided for review, suggesting that the problem was that the tracking system had not been fully updated. Overall, as discussed with regard to Sections C61, C62, and C63, BSDC had made good progress with regard to the development and implementation of quality BSPs. In addition, through the BSRC, the Facility had a process for sustaining the improvements made. The Independent Expert Team recommends that the parties consider this as an area in which less oversight is necessary.
C62	In developing and implementing these positive behavioral support plans, the psychologists shall	*Areas Requiring Focused Effort* ▪ *The rationale for specific interventions and identification of how the hypothesized function of the behavior logically led to the specific intervention should be clearly identified, but were not*

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	adequately document their clinical findings and the treatment hypotheses to be tested, and set forth how treatments are derived. The psychologists shall also document their rationale for using specific behavioral interventions.	*consistently found in the BSPs reviewed.* Specification of the rationale for specific interventions and identification of how the hypothesized function of the behavior logically led to the specific intervention was addressed in the BSP template. BSRC Peer Review Checklist indicators included whether the function of the behavior was identified, and whether the replacement behavior was functionally equivalent to the target behavior. A review of recently approved BSPs indicated that, in those cases where an explicit rationale for the selected interventions was not included in the Behavior Assessment Report, the connection between the hypothesized function of the target behaviors and the identified replacement behavior was generally sufficiently clear as to constitute an implicit rationale.
C63	The State shall ensure that psychologists write concise and simple-to-use positive behavioral support plans at a level that can be easily understood and implemented by direct care staff.	*Areas in which Less Oversight is Necessary* ▪ *BSPs were shorter and the format had been altered so that critical information for staff implementation was separated out into a relatively concise document.* *Areas Requiring Focused Effort* ▪ *Continued effort to increase readability was warranted.* A review of recently approved BSPs indicated that they are generally written at a level appropriate to the readers. BSRC minutes provided evidence that BSP reviews included attention to readability.
C64	The State shall improve implementation of behavioral plans at the direct care staff level. As part of this initiative, in conjunction with outside consultants, as appropriate, the State shall provide regular and ongoing competency-based training to direct care and supervisory staff on how to properly redirect residents' behaviors pursuant to each resident's plan, without resorting to the undue use of planned or unplanned mechanical, physical, or chemical restraints.	*Areas in which Less Oversight is Necessary* ▪ *The Behavior Support Plan Procedure and Competency assessment form provided for review in January 2012 appeared to be an adequate approach to competency-based training on BSPs.* *Areas Requiring Focused Effort* ▪ *In January 2012, staff indicated that the competency assessment was occurring in a pilot program in one ICF, but was not being routinely implemented across the Facility as required by the Settlement Agreement.* At the time of the most recent review, competency checks were regularly being developed for BSPs. The Procedure and Competency document was seen as the primary description (for staff) of behavioral intervention procedures in the BSP. The Facility provided abundant evidence of frequent BSP competency checks across ICFs. The 4th Quarter (2013) Quality Improvement Report indicated that, of 94 Treatment Integrity/Competency Checks conducted during the quarter, 93 (99%) were said to be at or above 80% compliance.

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		Staff noted that every ICF had a dedicated Behavior Support Specialist to assist direct support personnel and others in implementing and monitoring BSPs. ICF Administrators reported good satisfaction with the contributions made by Behavior Support personnel. The evidence of frequent competency checks was one indicator of the impact of these dedicated specialist positions. Overall, BSDC had made good progress with regard conducting competency-based training for staff on the implementation of BSPs. The Independent Expert Team recommends that the parties consider this as an area in which less oversight is necessary.
C65	Both skills training and positive behavioral supports shall be developed and implemented as part of a resident's overall individualized plan. The State shall ensure that there is effective coordination and integration of services and treatment modalities, including psychology, psychiatry, neurology, nursing, medical and health care, and other needed services.	*Areas in which Less Oversight is Necessary* ▪ *Generally, behavior supports were developed and implemented as part of individuals' overall individualized plans. This was evidenced through BSP goals and objectives generally being included as Needs/Goals/Objectives in the IPP, and coordinated with other team members at team meetings. Such team meeting generally included nursing staff, and increasingly included primary care physicians. IDTs met with the psychiatrist during quarterly psychiatric clinics. Documentation of these clinics as IDT meetings, including formal modifications to individuals' plans as necessary had been instituted, and served as an improved record of integration of psychiatry.* *Areas Requiring Focused Effort* ▪ *There did not appear to be any documentation of coordination and integration of services with respect to neurology, or consistent documentation of coordination with primary care physicians (PCPs) (i.e., some improvements were seen in PCPs' attendance at IDT meetings, including psychiatric clinics). At neurology clinics, there should be a sign-in sheet. In addition, the QDDP will document attendance, and the neurologist should include information about attendance in his/her notes. Every Monday and every Thursday, medical staff meet with nursing staff, PCPs and specialists. They talk about individuals and the need to coordinate and integrate services. The Independent Expert Team will ask for examples of where this occurred.* Staff reported that evidence for integration of neurology, psychiatry, and primary care was being tracked in the QI system. The indicator: "Standards of Practice – Management (SOP-M) including neurological and psychiatric documentation and management" was reported to be 97% compliant for the 4th quarter of 2013 and 99% for all of 2013, although this indicator appeared to be measuring something other than "integration of neurology, psychiatry, and primary care." A request for documentation from the most recent three months of joint psychiatry/neurology/primary care clinics yielded notes from 37 clinic sessions. A representative from psychiatry and a representative from neurology attended all of them. The individual's primary care provider also attended nineteen clinic sessions (51%). Thus, there was "documentation of coordination and integration of services with

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		respect to neurology" in every instance, and "documentation of coordination with primary care physicians" about half of the time. Staff reported continued efforts to achieve coordination between BST members and Speech/Language professionals with respect to behavior support planning: ▪ Staff cited examples of plans resulting from such coordination that led to a communication goal that served as the replacement behavior in the individual's BSP. A request for documentation of such coordination yielded BSP data sheets for two individuals that tracked communication behaviors (as replacement behaviors). In summary, mechanisms appeared to be in place to ensure that adequate coordination was occurring between the Behavior Support Team and neurology and psychiatry, and improvement with regard to the integration of speech and language with behavioral therapies was maintained. Regular coordination with primary care physicians appeared to be weaker, suggesting a need for further effort by the Facility.
C66	On or before January 1, 2009, the State shall maintain an effective Behavior Intervention Committee review process for the development and implementation of positive behavioral support plans, with an emphasis on stringent review and approval of restrictive interventions.	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January 2012 review, the Behavior Support Review Committee (BSRC) had been re-started and had been active in reviewing updated BSPs. With regard to the constitution of the committee, a licensed psychologist chaired the BSRC, and the presence of a BCBA was required for all reviews. All members of the BST were invited to participate in the BSRC reviews.* ▪ *Similarly, the membership of the HLRC had been expanded and included two Community Members (one of whom was a licensed pharmacist), four parents or guardians, the Chair (BSDC Advocacy Manager), three BSDC staff members (QDDP Coordinator, Director of Nursing, and Home Room Facilitator), and two persons with behavioral training and expertise (a private provider's Director of QI and a Compliance Specialist). The addition of the Director of Nursing and the pharmacist brought medical expertise to the committee that was previously missing. Although it would be beneficial to have more members with psychological or legal experience, the current composition appeared adequate.* *Areas Requiring Focused Effort* ▪ *Priorities for the BSRC include: 1) ensuring all new and revised BSPs and Safety Plans are reviewed and copies of current approval is maintained in the individual's record; 2) conducting thorough reviews to ensure requirements of the Settlement Agreement are met as well as other generally accepted standards, as appropriate; and 3) ensuring a process is in place to confirm recommended changes are made.* Of note, staff reported that the Facility currently had five BCBAs on campus (plus one behavior analyst intern), representing a pool of behavioral expertise that has substantially increased over time.

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		It appeared that all new and revised BSPs were receiving review by the appropriate bodies (i.e., IDT, BSRC, HLRC), depending on the presence and level of restrictive intervention included. The process outlined for the BSRC appeared to be adequate to assess compliance with requirements of the Settlement Agreement. The Habilitation Record Audit form included a check as to whether the record included current BSPs, Safety Plans, and approvals. A small informal sample of BSPs (n=7) located in individuals' program books indicated that most included documentation of review within the previous 12 months. One exception (i.e., Individual #237) indicated that the associated IPP date was 9/19/12 with no documented review or revision since that time. A request for and review of this BSP indicated that the current version included documentation of a recent revision (10/17/13). Thus, it appeared that, in this case, the BSP in the individual's program book had not been updated to the current version. As noted in a previous report, the current BSP policy (5.1 Behavior Supports – Effective 9/18/12) included the requirement that "… the BSRC Chair ensures that all appropriate and required changes are made prior to giving final approval." On the copies of BSRC minutes provided for review, the statement "REQUIRED CHANGES MADE AND REVIEWED BY CHAIR: YES NO" was often left blank. Sometimes, this line was marked "pending," in a few cases it was marked "Yes," and in a few cases it was marked "No." Thus, at least in these versions of the minutes, they generally lacked documentation that required changes were made and reviewed. ▪ *Priorities for the Human Legal Rights Committee include: 1) finalizing the handbook and implementing related training requirements for HLRC members; 2) developing objective criteria according to which they can evaluate requests for general anesthesia for dental work, requests for restrictive support devices to prevent falls, and/or restrictive medical interventions or devices; 3) ensuring all new and revised BSPs that include restrictions and Safety Plans are reviewed and copies of current approval is maintained in the individual's record; 4) ensuring "stringent" review occurs of all restrictive interventions as well as the plans in place to potentially reduce the restrictions; and 5) ensuring a process is in place to confirm recommended changes are made, particularly when approval is not granted.* Facility staff reported that there had been no changes to HLRC personnel over the past year, and that other staff members expressing an interest in joining the HLRC when there was an opening had approached the chair. HLRC members were reportedly providing a rights orientation for all new staff. Four 2013 QI indicators related to the HLRC were as follows:

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		▪ Do all HLRC requests include plans for reducing restrictive interventions? (4th Quarter QI report: 76%; however, there was steady improvement across the four quarters of 2013). ▪ Is there documented consent for emergency interventions? (4th Quarter QI report: 100%) ▪ Are requests that are denied by HLRC abandoned? (4th Quarter QI report: 100%) ▪ Did HLRC approve restrictive procedures in BSPs and Safety Plans? (4th Quarter QI report: 100%) The HLRC Chair indicated that a different indicator was substituted for 2014: o Are all BSPs and Safety Plans with restrictive components being reviewed by the HLRC? (HLRC Chair reportedly reviews non-restrictive plans to monitor this indicator.) HLRC personnel indicated that the committee has generally been asking for more data to justify requests for restrictive interventions. The committee reportedly had been working with members of the PT/OT department with respect to a checklist to help properly assess restrictiveness of supportive devices. The committee also received training regarding how the checklist was completed when there was a request for general anesthesia. The HLRC chair indicated that she had been participating in the Bridges HLRC once per month, and sitting in on meetings of the HLRC for a local provider. In summary, improvements with regard to the HLRC process apparently had been sustained and extended. The "Areas Requiring Focused Effort" related to the HLRC appeared to have been adequately addressed.
Monitoring and Follow-Up		
C67	The State shall develop and implement an effective system to regularly monitor each resident's skills training and positive behavioral support plans. The monitoring of the skills training and positive behavioral support plans shall produce prompt and effective follow-up action to ensure that: (a) the direct care staff are effectively implementing the skills training and behavior support plans, (b) the skills training and behavior support plans are effective and producing training	*Areas Requiring Focused Effort* ▪ *With regard to skill training programs and BSPs, adequate quarterly and annual reviews of progress should be completed, including summaries of progress that meaningfully reflect individuals' progress toward IPP goals, analysis of data trends and active interpretation to yield substantive changes in intervention programs, detection of a lack of progress and appropriate response in a timely and effective manner, and review and revisions, as appropriate, to BSPs in response to significant events or deteriorating behavior trends.* In the IPPs reviewed during this review, interpretations of progress data generally appeared to be accurate and appropriate for both BSP and habilitation program objectives. Team decisions regarding continuation/revision/termination of objectives were generally consistent with the progress data and interpretation. An exception was the progress report on the first BSP objective for Individual #352. Data reported for all three months in the quarter indicated that he performed the behavior on over 100% of opportunities (106%, 111%, 123%). A careful review of progress data should have detected this error and corrected it in the first month.

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	and treatment outcomes specified in each resident's plan, and (c) where the residents are not making progress, the skills training and behavior support plans are modified appropriately and whenever necessary, and implemented promptly thereafter.	The 4th quarter QI report for 2013 indicated that 43% of individuals' IPP objectives were met, compared to 37% in the 4th quarter of 2012. While this indicator did not speak directly to the "meaningful reflection of individuals' progress toward IPP goals," it might offer a global sense of program effectiveness. Constructive interpretation of this global indicator will recognize that it is meaningful only if objectives and criteria for mastery are being appropriately selected based on individuals' needs and abilities. As noted in a previous Independent Expert Team report, Facility staff indicated that three months of a downward trend in behavior data led to a review with the BST member responsible for the BSP and consideration of the need for a peer review of the BSP. The template for the Behavior Support Plan Monthly Note included a query about whether a "3-months decline" was shown, indicating a need for BSRC review. Examples of internal peer review checklists for monthly progress notes were generally positive. A review of the internal peer review checklists for progress notes frequently noted weaknesses with respect to the items: "Larger Context of Behavior… Was Explained, " "Noted Reliability of Data," and "Communication Issues Affecting Performance Are Addressed." Thus, there were processes in place that, if implemented with integrity, should yield improved monitoring of individuals' progress on their BSP goals.
C68	This monitoring system shall include tracking of systemic and individual outcome measures, with variables including, but not limited to: the incidence of resident behaviors, the use of restraints, the use of emergency procedures, and the implementation and monitoring of behavior plans. The State shall promptly and effectively address any systemic or individual problems identified through monitoring.	*The system used to track restraints is discussed in further detail below with regard to Section C72 of the Settlement Agreement.* *Areas Requiring Focused Effort* ▪ *As noted with regard to Section C64, in January 2012, staff indicated that the competency assessment/fidelity monitoring was occurring in a pilot program in one ICF, but was not being routinely implemented across the Facility as required by the Settlement Agreement. Such a system should be implemented across all ICFs/ID, including a data system to track fidelity and detect implementation problems, a systematic process for responding to fidelity problems, and a method of summarizing and reporting fidelity to provide supervisors with regular updates on this aspect of behavior intervention.* The BST had sustained regular treatment integrity monitoring throughout the Facility. Document request V.17 yielded treatment integrity monitoring sheets from 15 homes. The 4th quarter 2013 QI data for the indicator: "Portion of BSP Competency checks that are scored 80% or higher for adequate or excellent ratings" reported that 99% of the Competency Checks indicated compliance with the plan. Thus, a system had been put in place for summarizing the monitoring treatment integrity checks and

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		reporting the results to ICF administrators and performance data appeared to be positive. This is an area in which it would appear less oversight is necessary.
Priority Group		
C69	Based on the assessments and the monitoring, the State shall create a list of behavioral priority residents for heightened and enhanced attention and focus. This priority group shall consist, at least, of those residents who have already had a planned or unplanned mechanical, physical, or chemical restraint, those residents with a dual diagnosis of mental illness, those residents with significant or challenging behavior problems, as well as those residents who sustain or cause frequent injuries or are at risk of serious harm due to their behaviors.	*Areas Requiring Focused Effort* ▪ *At the January 2012 review, BSDC provided the Monitoring Team with a list of individuals in the priority group (N=11). However, given that the Facility's plan to re-administer the Behavior Problems Inventory (BPI) twice yearly had not occurred, it was unclear how the Facility formulated this list. Based on information the State provided, BSDC is using a variety of other tools. Priorities have been identified, so that screening is not done just for the sake of screening, but is reflective of the individual's specific needs. Medical issues also are being ruled out first.* Staff reported that the BPI was administered once per year for individuals with "high" or "highest" risk, and these individuals reportedly were subjected to more frequent chart reviews and BSP reviews. Staff also noted that some individuals have been removed from the Priority list due to decreased risk and decreased significant events. The current priority list identified four individuals for the "HIGHEST Behavioral Needs Group" (i.e., individuals who scored high on the BPI, had a BSP, and had one or more use of restraint in the past year). Twenty-three individuals were identified for the "HIGH Behavioral Needs Group" on the basis of scoring high on the BPI and needing a BSP, but having had no restraint usage or on the basis of scoring "moderate" on the BPI, needing a BSP, and having one or more instances of restraint use. As noted previously, the intended function and practical effect of the Priority list had been clarified. In order to meet the letter of the agreement, the Facility should include consideration of "dual diagnosis of mental illness" and "sustaining or causing frequent injuries" as criteria to be used in formulating the list. However, the present procedure generally appeared to meet the spirit of this provision of the agreement.
C70	In close consultation with outside consultants, as appropriate, the State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, through augmented and enhanced skills training and habilitation, positive behavioral supports, mental health	*Areas Requiring Focused Effort* ▪ *Although external consultation was sought for at least one individual, at the time of the January 2012 review, the BST staff did not appear to be aware of how the priority list was generated or what purpose it was intended to serve. For those individuals currently on the list and for those added to the list through implementation of formal processes designed to identify those at risk behaviorally, the State should provide necessary supports, and document its efforts to actively address the needs of individuals on the Behavioral Priority List. In order to assess the Facility's efforts, the Independent Expert Team will look at what has happened with a sample of individuals on this list.* The priority list procedure indicated that individuals in the "HIGHEST Behavioral Needs Group" would

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	care, and other interventions and treatment modalities, including an increased emphasis on community living and/or more structured, meaningful, and integrated habilitative activities in the community. These protections, supports, and services shall meet the resident's individualized needs without relying on the use of restraints. The intent here is to minimize or eliminate the triggers for behaviors, minimize or eliminate the behaviors themselves, and minimize or eliminate the use of restraints.	have a new functional assessment and BSP "at least every year," while the Behavior Support Review Committee would review those in the "HIGH Behavioral Needs Group" at least once per year. No documentation was offered regarding use of external consultation for individuals on the priority list. Current data for one individual on the "Highest" list was available for review. Long-term (one year) trends for dangerous target behaviors were positive (i.e., they were decreasing), and did not indicate a need for external consultation. However, another individual on the "Highest" list (Individual #9) experienced 29 instances of a physical hold in the approximately one-year period between the Independent Expert Team's visits. While there were numerous IDT meetings held in response to these restraint episodes (as noted below with regard to Section C76), the frequency of the episodes, the fact that multiple episodes were reported in each month (March 2013 through January 2014), and the fact that total minutes in restraint for this individual (67 minutes) in the fourth quarter of 2013 exceeded the total minutes of restraint for all BSDC residents for each of the preceding three quarters suggested that he would be a candidate for external consultation. In its response to the draft report, the State indicated that an external BCBA and another external behavioral consultant reviewed Individual #9, and a third Ph.D. Psychologist provided consultation through the BSRC. It would be helpful for IDT meeting minutes to reflect the external consultation provided, including the team's consideration of the resulting recommendations, and decisions about whether or not to implement the recommendations.
C71	The steps necessary to achieve such positive outcomes for the residents in this priority group may include: daily interdisciplinary team meetings, regular contact with outside consultants, as appropriate, close observation of the residents and their staff, daily competency-based training of staff with regard to how to properly implement needed interventions, regular revision of plans and approaches, changes in the living environment, more frequent contact with people in the community in normal settings, and more meaningful and engaging day activities in the community.	*This is covered and should be combined with Section C70.*

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Restraints		
C72	The State shall ensure that all residents are free from unreasonable restraint. The State shall develop and implement effective measures to minimize significantly or eliminate entirely the use of mechanical, physical, and chemical restraints on BSDC residents. The State shall ensure that restraints are not used as punishment, in lieu of habilitation, skills training and behavior support plans, or for the convenience of staff. Any restraint used will be the least restrictive form of restraint.	*Areas Requiring Focused Effort* ▪ *BSDC needed to develop and implement a policy to address the use of medical restraint, including HLRC review and requirements that the IPPs for individuals for whom it is approved include some active training program aimed at reducing the need for medical restraint. The State indicated that medical restraint should be included in the policy, and should be treated as any restraint would be. A new policy has been drafted, but has not yet been approved. The Independent Expert Team will review the revised policy.* ▪ *Consistency was needed with regard to the ICFs/ID review of restraints, and development of quality plans to address the continued reduction of restraints. The QI Department is taking responsibility for the review of restraints.* ▪ *At the time of the January 2012 review, the Restraint Reduction Committee had not met since October 2011. Regular meetings of this committee should be held, and recommendations developed to address factors contributing to restraint, with follow-up taken and documented in minutes. The State indicated that the State Building has a restraint reduction committee, because there is higher use of restraint at this ICF/ID.* ▪ *Restraint reviews should include explicit attention to the question of whether the restraint was used as a last resort to protect individuals from injury, as required by policy.* Data reported on restraint usage was positive. The 4th Quarter 2013 Quality Improvement Report indicated a continuing decline in instances of restraints (eight instances for the quarter, compared to 22, nine, 11, and 11 in the preceding four quarters). A similar decline over the past year was noted in the number of individuals experiencing restraints. Only one individual used physical restraint in the 4th quarter for a total of 67 minutes. The Report documented zero instances of use of mechanical restraint and zero instances of use of chemical restraint in the year 2013. One individual required the use of medical restraints in 2013, 11 times in the six months before the review. Document request V.21a produced a log of one-time [psychiatric] medication in instances of behavioral crisis. Over the previous six months, there were six instances, three of which involved one individual. Facility staff reported that use of mechanical restraint remained at zero. Facility staff reported that each occurrence of a physical hold resulted in a review by the Incident Review Team and an exploration of the event by a Behavior Support Specialist. They noted that the frequency of physical holds had decreased. Injuries related to restraint usage were low. In the year preceding the review, two instances of minor injury to an individual were reported and two injuries to staff members were reported (severity not noted).

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		The 4th Quarter 2013 Quality Improvement Report indicated continuation of a declining trend in peer-to-peer aggression incidents (eight allegations of peer-to-peer abuse for the quarter, compared to an average of 12.75 alleged incidents for the quarters of 2012). The method for reporting restraint usage had previously been standardized across ICFs. As noted in previous reports, the Facility had not re-constituted a Restraint Reduction Committee. However, in view of the process for responding to restraint episodes (as discussed elsewhere) and the reduction in overall use of restraints, the spirit of this provision appeared to be honored, despite the absence of a formal Restraint Reduction Committee.
C73	Restraints shall not be a part of any positive behavioral support plan and restraints shall not be used as a learning-based contingency to reduce the frequency of a behavior. Restraints may only be used for medical reasons or when there is immediate risk of harm to self or others (*i.e.*, to interrupt or terminate a seriously dangerous situation where injury could result). The State shall revise its policy definition of immediate risk of harm to self or others to ensure that the justified use of restraints is minimized. The State shall ensure that restraints labeled as "medical" restraints are not, in fact, used for behavioral purposes or control. The State shall continue to prohibit the use of all prone physical and mechanical restraints.	*Areas in which Less Oversight is Necessary* ▪ *BSDC's Physical and Mechanical Restraints Policy, #5.4, effective 8/27/11, was consistent with the requirements of Section C73 of the Settlement Agreement.* ▪ *In most cases, discussion of use of restraints had been removed from BSPs and placed in Safety Plans.* ▪ *Restraint records provided for review in January 2012 indicated that, at least in those instances, restraint was used only when there was an immediate risk of harm to the individual or to others.*
C74	In order to minimize or eliminate the use of restraints generally, the State shall ensure that the staff are adequately and appropriately implementing all aspects of each resident's overall individualized	*This requirement is connected to the competency-based evaluation/fidelity monitoring required in Sections C64 and C68. As indicated with regard to these sections, in January 2012, a pilot was being implemented in one ICF/ID.*

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	plan, including aspects related to positive behavioral supports, skills training and habilitation, mental health care, and integrated community living and activities. The State shall ensure that the supervisory and professional staff are regularly monitoring the individualized plans and their implementation to ensure that the plans and their implementation are effective and producing the desired reduction or elimination in the use of restraints. Where plan modifications are needed to address a resident's restraint usage, the State shall ensure that appropriate plan revisions are promptly developed and implemented.	
C75	The resident's psychologist shall begin the regular practice of reviewing, by the next working day, each use of mechanical, physical, or chemical restraint (excluding planned medical restraints), so as to ascertain the circumstances under which such restraint was used. The psychologist will conduct an analysis of what antecedents or circumstances may have prompted the behavioral escalation that led to the use of restraint. The psychologist shall analyze at least these variables: whether the behavior plan as written and/or implemented is effective in addressing the resident's	*Areas Requiring Focused Effort* ▪ *Given that during the January 2012 review, a request for this information generated only information for Bridges, BSDC needed to develop and/or implement a process for meeting this requirement.* As noted in previous reports, Facility staff indicated that all instances of restraint use were reported to the Director of the BST, who subsequently contacted the BST member serving the restrained individual to determine what steps were taken by the team in response to the restraint episode. Document request V.22 yielded documentation that, in each of the most recent five restraint episodes, a member of the BST followed up in some fashion. In two instances, follow-up occurred the day after the restraint, in one instance follow-up occurred two days after the restraint, in one instance follow-up occurred four days after the restraint, and in one instance follow-up occurred ten days after the restraint. In four of five cases, there was a special IDT meeting regarding the incident (held one, one, four, and 11 days after the restraint).

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	behaviors; whether the living environment is overly restrictive and segregated; whether the living environment is overly crowded and/or fosters conflict with too much exposure to other residents prone to behaviors; whether there is adequate skills training, habilitation, and/or meaningful community activities throughout the day; and whether the resident is receiving adequate and appropriate treatment for his or her mental illness. The psychologist will then promptly develop, and the staff will implement, individualized measures to minimize or eliminate such antecedents or circumstances.	
C76	If any resident is subjected to three or more restraints within a 30-day period, the State will convene a meeting of the resident's interdisciplinary team, including the psychologist, to conduct a comprehensive review of the effectiveness and appropriateness of the resident's existing protections, supports, and services. This team meeting shall take place on the first working day following the third restraint. The team meeting shall include the input and analysis of outside consultants whenever possible. The team shall promptly develop, whenever necessary, alternative and/or more tailored and intensive protections, supports, and services that meet	*Areas Requiring Focused Effort* ▪ *Although it was unclear whether documentation existed, but was not submitted in response to the Monitoring Team's request, problems were noted with regard to teams meeting and conducting adequate reviews within one business day of three or more restraints. Focused efforts should be placed on both the timely review and comprehensiveness of the reviews conducted when this criterion is met.* In the year preceding the monitoring review, two individuals met the "three restraints in 30 days" criterion. For one individual (i.e., Individual #14), records indicated that an IDT meeting was held on the day after the criterion was met. The second individual (i.e., Individual #9) experienced 29 instances of a physical hold in the period between the Independent Expert Team's visits. During that period, records indicated 10 IDT meetings to address restraint episodes. In most cases, IDT meetings occurred on the same day or the day after the restraint that met the criterion, but in one case the period between meeting the criterion and the IDT meeting was 21 days. Sixteen of those restraints and six of those IDT meetings occurred after the most recent revision of the individual's BSP. The Facility is encouraged to continue to emphasize the need to respond proactively to repeated restraint usage. However, in light of the low, and decreasing, overall frequency of restraint use, the Independent Expert Team recommends that the parties consider this as an area in which less oversight is necessary.

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	the resident's individualized needs, but that do not rely on the use of restraints. The team shall make specific recommendations and shall document these recommendations in the resident's record, making changes in the resident's individualized plan whenever necessary. These recommendations in the revised plan shall be implemented promptly and properly to meet the resident's plan.	
C77	The parties anticipate that the use of mechanical, physical, and chemical restraints at BSDC will become a very rare occurrence. When utilized, however, staff shall take the following steps and precautions: (a) provide immediate notification to an on-site supervisor upon the use of any restraints; (b) provide notification to and obtain the approval of a psychologist and/or nurse if any restraint is applied for longer than one hour, and upon each hour thereafter; (c) ensure that a nurse provides a timely assessment that the restraint is being safely applied and is reasonably tailored to the resident's behavior; (d) provide continuous monitoring of the resident while restrained to ensure safety; ensure that a nurse or senior supervisor monitors and	<u>Areas in which Less Oversight is Necessary</u> ▪ *At the time of the most recent review, BSDC had begun to use a new form entitled Crisis Intervention Record. It included the elements the Settlement Agreement requires, except for the nursing piece identified below.* ▪ *Generally, restraints were of short duration and did not reach the one-hour limit that would require adherence to some of the specific requirements of this section.* ▪ *Generally, the forms were filled out completely to address the specific requirements of this section.* <u>*Areas Requiring Focused Effort*</u> ▪ *The current form for documenting restraint did not address the requirement that "a nurse or senior supervisor monitors and documents the residents' vital signs, respiration... at least every hour the resident is restrained." The Independent Expert Team will ask for the nursing notes that correspond with the restraint episodes.* *Due to limited review during the January 2012 visit, this is an area that the Monitoring Team needs to look at in more depth during the next review, particularly to provide adequate comments on the adequacy of: a) nursing staff' review; and b) release from restraint "as soon as the resident is determined not to pose an immediate risk of harm to self or others."* An examination of the restraint log indicated that no individual at BSDC had been restrained for more than 30 minutes in the past year. The Facility is encouraged to maintain vigilance and routine monitoring to ensure that the requirements are met in any instance in which restraint is required. However, recent data indicated that "the use of mechanical, physical, and chemical restraints at BSDC" has become a "rare occurrence," as anticipated in the Settlement Agreement.

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	documents the residents' vital signs, respiration, circulation, and mental status at least every hour the resident is restrained; release every restrained limb from restraint, examine it for bruising and skin tears, and allow exercise of the limb at least ten minutes every hour; provide the restrained resident with an opportunity to eat, drink fluids, and toilet, as needed; provide every resident in restraint with continuous one-to-one supervision; and (e) release every restrained resident from restraint as soon as the resident is determined not to pose an immediate risk of harm to self or others.	
C78	The State shall ensure that staff are adequately trained on the proper use of restraints.	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January review, the Facility's data showed that for both Relational/Conceptual/Technical (RCT) Mandt training and Advanced Mandt training, 100% of staff requiring training on restraint had completed up-to-date training. The Mandt training was adequate, competency-based training.*
C79	The State shall document each use of mechanical, physical, and chemical restraint, including the date and time of use, the events leading to the restraint, the exact type of restraint or procedure used, as well as the length of time it was used. Documentation of each use of restraint shall be kept in the resident's file and in a central location.	*Areas in which Less Oversight is Necessary* ▪ *The Crisis Intervention Record included documentation of the date and time of use, the events leading to the restraint, the exact type of restraint or procedure used, and the length of time it was used. As noted in relation to Section C77, the records reviewed were completed adequately with respect to the description of the restraint episode.*
C80	The State shall ensure that	*This provision of the Settlement Agreement is discussed with regard to Section C89.*

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	chemical restraints meet appropriate levels of approval and oversight by a psychiatrist, psychologist, and physician prior to their administration. Staff shall collect adequate data on the effects, as well as adverse side effects, of each individual administration of such medications. The psychiatrist, psychologist, and physician shall consider the data collected when making future clinical intervention decisions. The State shall prohibit the use of standing PRN or "stat" orders for chemical restraints.	

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

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Steps Taken to Assess Status: The following activities occurred to assess status:

- **Review of Following Documents**:
  - Individual #144: Annual H and P of 4/15/13; notes from medical contacts over the last six months; laboratory studies, lists of medications dispensed, and side effect monitoring forms over the last six months; and information sent to guardians regarding informed consent
  - Individual #48: Annual H and P of 12/10/13; notes from medical contacts over the last six months; laboratory studies, lists of medications dispensed, and side effect monitoring forms over the last six months; and information sent to guardians regarding informed consent;
  - Individual #47: Annual H and P of 10/8/13; notes from medical contacts over the last six months; laboratory studies, lists of medications dispensed, and side effect monitoring forms over the last six months; and information sent to guardians regarding informed consent;
  - Individual #378: Annual H and P of 9/5/13; notes from medical contacts over the last six months; laboratory studies, lists of medications dispensed, and side effect monitoring forms over the last six months; and information sent to guardians regarding informed consent;
  - Individual #335: Annual H and P of 7/12/13; notes from medical contacts over the last six months; laboratory studies, lists of medications dispensed, and side effect monitoring forms over the last six months; and information sent to guardians regarding informed consent;
  - Individual #282: formal notes of psychiatric contacts, from 2/28/13 to 2/20/14; undated (but after 2/27/14) active and historical medication lists; and documents from emergency room visit of 1/2/14; and
  - Notes from Diagnosis Review meetings, from 11/19/13 to 3/25/14.
- **Interviews with**:
  - Todd Stull, MD, BSDC Medical Director.

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C81	The State shall provide adequate and appropriate routine and emergency psychiatric and mental health services to meet the individualized needs of each resident. These services shall be developed to ensure and protect residents' rights.	*As the overarching requirement, adequate implementation of this subsection is dependent upon the State addressing Sections C82 through C89.* *Areas in which Less Oversight is Necessary* ▪ *Generally, BSDC and Bridges were providing adequate routine and emergency psychiatric services. The details are provided below with regard to Sections C82 through C89. Psychiatrists were regularly reviewing individuals prescribed psychotropic medication, and this schedule could be easily modified to address an individual's needs.*
Adequate Psychiatric Hours		
C82	On or before October 1, 2008, the	*Areas in which Less Oversight is Necessary*

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	State shall procure additional psychiatry hours to meet the mental health needs of the residents. The psychiatrist(s) shall be well-respected with a demonstrated history of effectively meeting the needs of persons with developmental disabilities and a dual diagnosis of mental illness. The State shall provide residents with enough psychiatry hours to enable the psychiatrist(s) to conduct thorough and complete evaluations, develop carefully considered differential diagnoses, order appropriately tailored treatments, and provide regular and sufficient follow-up monitoring to determine whether ordered treatments are, in fact, working to address the residents' underlying mental illness. If such treatments are not working, the psychiatrist(s) shall have enough time to conduct new evaluations, pursue alternative diagnoses and treatments, and monitor and follow-up again. The psychiatrist(s) shall have enough time to engage in this ongoing practice for all residents, including those residents with challenging behaviors associated with their mental illness. The psychiatrist(s) shall have sufficient time to see all residents frequently enough such that they are receiving effective treatment for their mental illness. The psychiatrist(s) shall have	▪ *At the time of the January 2012 review, according to schedules BSDC provided to the Monitoring Team, the two BSDC psychiatrists were providing 24 hours per week of direct psychiatric care at BSDC or Bridges. The psychiatrists followed approximately 64 individuals at BSDC. A total of 11 individual resided at Bridges at the time of the onsite review. Both psychiatrists had demonstrated experience in working with individuals with intellectual/developmental disabilities and coexisting mental illness.* *The psychiatrists appeared to have enough time to schedule regular and emergency meetings with individuals. There also appeared to be adequate time for the psychiatrist(s) to conduct thorough and complete evaluations develop carefully considered differential diagnoses, and order appropriately tailored treatments. There was adequate time for input from individuals, staff, and guardians. As noted above with regard to Section C81 of the Settlement Agreement, adequate time was available for interim and emergency follow-up, if treatments were not working. If the situation warranted, individuals could be seen quite frequently.*

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	sufficient time such that no primary care physician, physician's assistant, or registered nurse is primarily responsible for providing psychiatric follow-up care.	
C83	The State shall ensure that annually, or more often as needed, the psychiatrist(s) conducts a comprehensive assessment of each resident receiving psychotropic medication and each resident who has or may have a diagnosis of mental illness. The State shall ensure that for each resident assessed as having mental illness, the psychiatrist(s) documents a clinically justifiable, differential diagnosis consistent with DSM-IV-TR criteria. No resident shall have a current mental health diagnosis that is not clinically justified in the record.	*Areas in which Less Oversight is Necessary* ▪ *Adequate justification for clinical diagnoses generally was found in the records. Areas requiring additional attention are listed below.* *Areas Requiring Focused Effort* ▪ *Improvements were needed in ensuring that adequate justification was provided for diagnoses of Impulse Control Disorder and Intermittent Explosive Disorder (IED). The numbers of individuals with these diagnoses had decreased. Many individuals started with these diagnoses, and as the current psychiatrists have worked with individuals, it has been a matter of proving otherwise.* ▪ *Attention also should be paid to ensuring complete Axis III diagnoses.* The Independent Expert Team's previous reports have commented on the questionable validity and utility of the diagnoses of Impulse Control Disorder (ICD) and Intermittent Explosive Disorder (IED) in individuals with intellectual disabilities. During the most recent review, the BSDC Medical Director told members of the Independent Expert Team that the BSDC Treatment Team was meeting to clarify and "clean up" all individuals' psychiatric diagnoses in preparation for a transition to DSM-5. The team, made up of the treating psychiatrist and various members of the BSDC psychology team, had been meeting essentially monthly, discussing between ten and fifteen individuals per meeting. At the time of the Independent Expert Team's onsite visit in April 2014, the BSDC team was about half way through this process. Of the 53 individuals whose diagnoses had been reviewed, 31 had not changed, two had ICD diagnoses dropped, one had a change in level of ID from mild to moderate, fourteen had other diagnostic changes, five had plans to evaluate further (including two with diagnoses of ICD or Intermittent Explosive Disorder). The rationales for changes as described in the notes seemed well thought out. In an interview with the Bridges staff, the Independent Expert Team was told that Individual #282's psychiatrist recently had changed his diagnosis and that with the new focus, his medications were being cut down. His diagnosis had been changed from anxiety disorder to perhaps cyclothymia, though as the psychiatrist wrote (reasonably, in the reviewer's opinion) in his 1/16/14 report: "I am unsure how firm the diagnosis of cyclothymia is... most of his mood swings appear to be related to mood instability that can be attributed to his character disorder." The psychiatrist had successfully stopped the individual's Hydroxyzine, Trazodone, and evidently Citalopram (though, as noted later in this report with regard to Section D93, that was not clearly documented), cut down his Lorazepam and Prolixin, and started him on Thorazine in an off-label capacity that was justified in the record. With these medication changes, the

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		individual improved. In sum, it appeared that the BSDC and Bridges psychiatrists were paying close attention to the diagnostic criteria when making diagnoses, which potentially was also having a positive impact on treatment.
C84	The State shall ensure that the psychiatrist(s) develops and implements an overall mental health treatment plan for each resident with a diagnosis of mental illness, and provides ongoing monitoring and revision of the treatment plan. Any treatment must comport with the mental health diagnosis. The psychiatrist(s) shall ensure that there is proper coordination and integration of psychiatric services with other services and treatment modalities, including those in psychology, neurology, nursing, medical and health care, and other ancillary services.	*Areas in which Less Oversight is Necessary* ▪ *Psychiatric treatment generally was appropriate based on diagnosis, and when off-label use of medication occurred, adequate justification was provided.* *Areas Requiring Focused Effort* ▪ *An area in which continued work was necessary included the need for better coordination of care with other medical providers and/or members of the treatment team, particularly neurologists. The neurologist who had had issues is no longer treating individuals. The Independent Expert Team will review some records from the current neurologists.* ▪ *Although based on limited information, it appeared that improvements also still were needed in the information psychiatrists provided to consultants. A new form has been generated, which the Independent Expert Team will review.* During previous reviews, the Independent Expert review found that the BSDC had addressed the areas identified as requiring focused effort.
Psychotropic Medication		
C85	On or before January 1, 2009, the State shall implement and maintain the following requirements with regard to the use of psychotropic medication: (a) Prior to developing and implementing an appropriate treatment plan, the psychiatrist(s) shall review the current medication regimen of each resident to determine whether the type and dosage of the medication is appropriate and necessary, and then, if necessary, make any changes	*Areas in which Less Oversight is Necessary* ▪ *In the records examined for the January 2012 review:* ○ *The psychiatrists regularly reviewed the current medication regimen of each individual to determine whether the types and dosages of medication were appropriate and necessary, and made changes as indicated. The BSDC psychiatrists' notes explained rationales for medication regimens and described long-term plans. Since the last review, the quality of the notes had improved with regard to better documentation of prior interventions and interval history. (Section C85.a)* ○ *The psychiatric notes regularly referred to behavioral data that the team collected. It was impressive that the psychiatrists did not respond to every behavioral escalation with a medication change. (Section C85.b)* ○ *With few exceptions, when individuals at BSDC and Bridges were on typical antipsychotics, antipsychotic polypharmacy, anticholinergic medications, benzodiazepines, or high doses of psychotropic agents, these situations were clearly justified in the records. (Sections C85.c, C85.g, C85.h, and C85.i)*

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	in the medication regimen. (b) The psychiatrist(s) shall use psychotropic medication only as an integral part of the resident's individualized skills training and positive behavioral support plans. (c) The psychiatrist(s) shall carefully review the medication regimen of residents where current doses are above the generally accepted effective dose for any particular medication. (d) The psychiatrist(s) shall consult with the assigned psychologist and interdisciplinary team to determine whether the existing skills training and behavioral support plans are appropriate and whether different programs or interventions should be developed to address the resident's index behaviors and symptoms so as to reduce or eliminate the need for psychotropic medications. (e) The psychiatrist(s) shall consult with the resident's primary care physician, nurse, or other appropriate members of the resident's interdisciplinary team, to determine whether the harmful effects of the resident's mental illness clearly outweigh the possible	○ *With regard to the risk-versus-benefit analysis and coordination with the individuals' teams regarding potential side effects, generally, psychiatric care for individuals with tardive dyskinesia seemed appropriate; and with a few exceptions, the BSDC psychiatric team continued to do a good job with recommended schedules for medication monitoring, including electrocardiograms, metabolic monitoring, and abnormal involuntary movement screens. (Section C85.e)* ○ *The decision-making process for titrating medications was set forth clearly in the records. (Section C85.f)* ○ *There were ongoing attempts to manage individuals on the lowest necessary dose of these medications, and to minimize the number of medications the individuals were prescribed. (Sections C85.h and C85.i)* *Areas Requiring Focused Effort* ▪ *Based on information provided for the January 2012 review, BSDC had begun piloting a new system for monitoring for side effects for individuals on psychoactive medication. Although during a previous review, thorough and well thought out guidelines had been developed for monitoring individuals on psychoactive medications, it was not clear the extent to which the new process had been implemented. This is key information necessary for the psychiatrist to make decisions related to an individual's medication regimen and also relates to the risk-versus-benefit analysis. The State reported that a process involving nurses had begun to be implemented. In addition, some medication orders included specific requirements for side effect monitoring (e.g., weights, vital signs, etc.). Other options, such as the use of a Therap module that would provide side effect information as part of the medication pass process, were being considered. (Sections C85.a and C85.e) (Note: This is further addressed in relation to Section C88.)* ▪ *Similarly, potential drug interactions were not always considered and planned for. (Sections C85.a and C85.e)* ▪ *Follow-up on treatment plans continued to be occasionally problematic (i.e., when follow-up was specifically noted as necessary, subsequent notes sometimes did not show the follow-up had occurred). (Section C85.a)* *Section C85.d would appear to be covered under Section C84, which addresses coordination with other team members, including psychologists.* *The accuracy of psychiatric notes is addressed with regard to Section D93.* Previous concerns with regard to monitoring of side effects had been addressed with the implementation of the Psychotropic Medication Monitoring Scale. In the last report, this was an area in which the Independent Expert Team recommended less oversight was necessary.

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	harmful side effects of the psychotropic medication and whether reasonable alternate treatment strategies are likely to be less effective or potentially more dangerous than the medication. (f) The psychiatrist(s) shall ensure that the decision-making process for titrating medications up or down is clearly and fully set forth in each resident's record. (g) The psychiatrist(s) shall ensure that there is a clear and full justification for the use of any typical or "first-generation" anti-psychotic medications. (h) The psychiatrist(s) shall take care to reduce or discontinue benzodiazepines and anticholinergic medications that have been used for longer periods of time than are justified by the resident's psychiatric diagnosis. (i) The use of intra-class polypharmacy shall be minimized, and whenever it is used, the psychiatrist(s) shall fully justify its use in that resident's treatment plan.	
C86	The State shall better educate guardians about proper mental health care and address their concerns when medication changes are needed to meet residents' needs.	*Areas Requiring Focused Effort* ▪ *Although guardians at BSDC appeared to frequently be involved in decision-making related to psychoactive medication, problems had been noted with the content of the consents, and specifically, the individualization, and ease of understanding of the information. (Note: the Monitoring Team did not conduct an updated review of this in January 2012.) Based on information the State provided, this process was currently happening for everyone. The*

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		Independent Expert Team will confirm this through review of a sample. ▪ *Documentation from the Bridges program did not show guardian participation in the consent process. The Independent Expert Team will request documentation from the QDDPs about invitations sent and guardians' responses.* BSDC was in the process of modifying the information provided to guardians with regard to informed consent. A prior report from the Independent Expert Team stated: "The annual informed consent documents that were reviewed were generic, if easy to understand, and not person-centered. They listed possible side effects from all classes of psychiatric medications, whether or not the individual was taking them." To review the status of the modifications, the medical records for the last six months and information provided to guardians for five individuals residing at BSDC were reviewed and BSDC's Medical Director was interviewed. ▪ On 11/4/13, Individual #144 was started on the atypical antipsychotic Seroquel. On 12/10/13, it was stopped, and restarted on 1/3/14. According to the psychiatrist's note of 11/4/13, the guardian was involved in the decision to start the medicine: "...I had the opportunity to review... my recommendations with… the guardian." The information sent to the guardian in November 2013 had the same problems described above. It stated that the risks and common side effects of Seroquel were listed in an enclosed table. However, that table described the risks of atypical antipsychotics in a generic way and did not state that Seroquel was a medication in this class. In an interview with the BSDC Medical Director during the site visit, a member of the Independent Expert Team was told that as of January 2014, this problem had been addressed and that medication-specific information was now being disseminated to guardians. The specific drug information provided to the guardian upon his 1/3/14 approval of the restarting of Seroquel was not provided for review, so no statement could be made as to the adequacy and specificity of that information. ▪ In response to a request for "most recently developed medication side effect sheets provided to guardians," the State provided a Patient Education Monograph for the medicine Zyprexa. If this were representative of drug-specific information provided to guardians as of January 2014, the reviewer felt it would resolve his prior, above-mentioned concerns. ▪ Individual #48 was being given Lithium Carbonate. A specific, completely adequate Patient Education Monograph for this medication was provided to her guardian for approval on 1/14/14. ▪ Individual #47 was prescribed Depakote. His guardian did attend various psychiatric contacts via telephone. Throughout the notes reviewed, the psychiatrist was concerned, reasonably, that the Depakote might have been responsible for the individual's low platelet count. The information sent to the guardian that was provided for the Independent Expert Team's review was from 10/28/13, prior to the above-discussed improvement in information provided. It did not describe the blood issues as potential complications of the use of Depakote. At the 2/26/14 appointment, because of ongoing concerns about his blood counts, a plan was discussed to

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		decrease his depakote dose in the future, if he remained behaviorally stable. The reviewer appreciated that though the platelet problems were not included on the forms sent the guardian, the guardian was most likely made aware of them during his telephone interactions with the psychiatrist at the individual's appointments. ▪ The information sent to Individual #335's guardian that was provided for review by the Independent Expert Team was from 8/14/13, prior to the above-described improvement in information provided. At that time, she was on Effexor, a medication that had the potential to increase her blood pressure, of significance in her case, as she had a prior history of high blood pressure and medication treatment. The forms sent to her guardian did not mention this possibility, and did not mention the specific antidepressant she was on. In late August 2013, her Effexor dose was increased. By November, her blood pressure had increased and a blood pressure lowering medicine, Lisinopril, had been added. Both of those medications, the Effexor and the Lisinopril, were subsequently stopped because of medical complications. The information provided to the guardian with respect to the Depakote the individual was prescribed at the time was extremely limited. As reiterated previously in this report, one of the possible complications of Depakote use is the lowering of the number of platelets, the blood cells that help stop bleeding. This was a significant potential risk for Individual #335, who had a history of problems with her balance and a history of falls, and it was not mentioned in the information provided to the guardian. According to her H and P of 7/12/13, she had a history of low platelet counts dating back to 2010, and at that time, had multiple bruises scattered over her abdomen, legs, arms, and back. It noted various low platelet counts over the prior year, as low as 86,000 on 3/26/13. As described above, at counts below 100,000, mild injuries might provoke excessive bleeding. This issue was not mentioned in the psychiatric notes provided for review. In late November 2013, after a fall, she bled into her brain and needed surgery. During that hospitalization, the Depakote was stopped. By the next blood test provided, 2/18/14, the platelet count had returned to normal. ▪ Individual #378 was being treated with Lithium, Depakote, and Chlorpromazine (the latter medicine substituted for Zyprexa in August 2013). The information provided for the Independent Expert Team's review was sent to the guardian on 8/29/13, and had the same difficulties with these earlier information sheets as described above: there was essentially no information about Depakote, and while the form did list some complications of typical antipsychotics, it did not label the chlorpromazine as a member of this class. The guardian was involved in most of the psychiatric appointments via telephone (i.e., 10/7/13, 11/4/13, 12/5/13, and 12/31/13). A conflict with the guardian was described in the 12/31/13 note, where the guardian wanted an approach (stopping all of the psychiatric medicines) not supported by the treating psychiatrist. The guardian was upset that he was not having adequate input. The treating psychiatrist told the guardian he would be willing to transfer the individual's care if another option could be found. The Medical Director evidently became involved in discussions with the guardian, and alternative placements were starting to be explored.

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		In sum, although most of the records reviewed did not have the benefit of the more recent side effect information BSDC was providing to guardians, it appeared from examples provided, as well as interview with staff that the new process addressed the concerns articulated in previous reports (and illustrated in some of the records reviewed for this report).
Monitoring and Follow-Up		
C87	The State shall develop and implement an effective system to ensure that the psychiatrist(s) regularly monitors the residents with mental illness whenever needed, and make changes, when warranted, in the residents' treatment plans. For those residents who receive psychotropic medication, this monitoring shall be face-to-face, and shall be conducted quarterly by the psychiatrist(s), or more often as necessary based on the residents' current status and/or changing mental health needs. The monitoring review shall include a review of any current psychotropic medication provided, as well as a review of the pertinent behavioral and other data. Whenever necessary, the psychiatrist(s) shall provide a psychiatric re-assessment and revision to the treatment plan, as appropriate, for each resident who: i) presents a significant adverse change in symptoms/index behaviors; ii) an increase in significant injuries or incidents related to symptoms/index behaviors; or iii) is subjected to an increase in	*Areas in which Less Oversight is Necessary* ▪ *All individuals reviewed were seen at least quarterly, as required by the Settlement Agreement. As noted with regard to Section C81, psychiatrists were regularly reviewing individuals prescribed psychotropic medication and making changes to treatment plan, and this schedule could be easily modified to address an individual's needs.*

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	repeated restraint due to a significant adverse change in symptoms/index behaviors.	
C88	The State shall maintain an adequate system for detecting, reporting, responding to, and documenting any drug-induced side effects of psychotropic medication. The State shall provide effective competency-based training for staff that complete side effects monitoring forms.	*Areas Requiring Focused Effort* ▪ *Although in November 2011, use of a new checklist had been piloted/implemented at BSDC to better collect information about potential side effects, as of January 2012, the results of this were not yet clearly evident in the documentation reviewed for this report. Although the records often showed that the psychiatrists addressed many of the side effects brought to their attention, it will be important for BSDC, as well as Bridges to fully implement a reliable system for the identification and reporting of potential side effects, including competency-based training for staff responsible, as well as response to data from the side effect monitoring forms in psychiatric notes.* This is addressed above with regard to Section C85.
Chemical Restraint		
C89	Consistent with the restraint section above, when psychotropic medication is used on an emergency basis, a supervisor shall be notified immediately, there shall be continuous monitoring of the resident after administration of the medication, and a physician shall observe the effect of the medication by personally visiting the resident or directing supervision by a registered nurse. A psychiatrist shall review the use within 24 hours of the order being written if there are multiple administrations of the medication or if more than one order is written for different medications. The psychiatrist shall develop and implement measures to help prevent the emergency use of psychotropic medication in the future.	*Areas in which Less Oversight is Necessary* ▪ *Based on a review of records related to use of chemical restraint, supervisors were notified, psychologists were involved, the interdisciplinary teams met regularly to address the issues and modify plans as warranted, and the psychiatrists were actively involved and promptly adjusted medication regimens in response to the incidents, and considered the data in their clinical intervention decisions.* *Areas Requiring Focused Effort* ▪ *Clinician progress notes did not consistently document response to the emergency medications, as required in Section C80: "Staff shall collect adequate data on the effects, as well as adverse side effects, of each individual administration of such medications." BSDC should ensure that the requirement that the individuals' responses to the medication are assessed and documented clearly in individuals' records. To facilitate assessment of this requirement, the Facility will provide the Independent Expert Team with the list of individuals for whom medications that are included in the psychiatric plan for the management of unpredictable violent behavior have been administered.* Based on the findings from the last review, this was an area the Independent Expert Team recommended required less oversight.

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

SECTION D: Health Care and Related Services (D90 through D119)

Steps Taken to Assess Status: The following activities occurred to assess status:

- **Review of Following Documents**:
  - Training agenda and curriculum for any training provided to Health Care Coordinators including training rosters since the last review;
  - Training agenda for training provided by Healthcare Coordinators to Direct Support Professionals and/or Facility staff, including training rosters, since the last review;
  - Nursing notes related to five most recent instances of restraint for crisis intervention;
  - Nursing notes related to five most recent incidents of emergency use of psychotropic medications;
  - Updated form(s) used to complete an integrated health care plan;
  - Points of service for Dining, Oral Care, Medications, and Treatments included in IPPs and Nursing Care Plans for five individuals: Individual #201, Individual #192, Individual #221, Individual #296, and Individual #102;
  - For the past one-year period, any reports generated by the Facility's health care quality assurance program and any resulting corrective action plans, including information related to medical, dental, and/or nursing care;
  - An updated list (with run date) of individuals who have been identified as "health care priority residents," including name, age, date of admission, and residential/living unit, and area(s) of risk;
  - For the past one-year period, an updated list of individuals who were:
    - Seen in the Emergency Room, including name, age, date of admission, and residential/living unit, and area(s) of risk;
    - Admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es);
    - Been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial, etc.); and/or
    - Have had a swallowing incident (defined as an event during eating that required an emergency intervention), including the date of incident, item that caused the swallowing incident, and the interventions following the incident;
  - Over the last one-year period, a list of individuals who have died, including name of individual, date of birth, date of death, location of death, and cause of death, if known;
  - For deaths occurring since the last review, documentation supporting monitoring and implementation of individual as well as systemic recommendations from the mortality review committee, including at BSDC and in the community.
  - Any changes since the last monitoring visit to any policies, procedures and/or protocols addressing the: provision of nursing care, nursing documentation, changes of status, nursing "Performance Management Process," and/or revisions to the BSDC Nurse Practice Act;
  - Documentation of any competency-based training provided to nurses and/or direct support professionals on modified policies;
  - For the last six months, minutes from the following meetings, as applicable: Nursing Quality Assurance, Department of Nursing, Peer Review for Nursing, and "Ongoing Meeting" (Medical, Nursing, Residential);
  - For the last six months, any data summaries and/or quality assurance/enhancements reports used by the Facility related to nursing, including subsequent corrective action plans;
  - Mortality review documentation for the following individuals: Individual #219, Individual #388, Individual #123, and Individual #136; and
  - For three individuals from each ICF/ID for whom Nursing Care Plans have been developed and/or updated within the past three months, their most recent nursing care plans with documentation supporting competency-based education on plans for direct support staff, including Individual #197, Individual #208, Individual #192, Individual #55, Individual #201, Individual #326, Individual #359, Individual #268, Individual #384, Individual #296, and Individual #251.
- **Interviews with**:
  - Todd Stull, M.D., Medical Director BSDC;

- Janelle Ramsborg RN, Outgoing Director of Nursing (DON), BSDC; and
- Helaine Dominguez, RN, CDDN, Incoming DON, BSDC.

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Principal Requirement		
D90	The State shall provide residents with adequate, appropriate and timely preventive, routine, acute, and emergency health care, including neurological care, to meet the individualized needs of the residents. The State shall develop and implement policies to guide the delivery of general and preventative medical care to meet the needs of the residents and require appropriate physician participation in the interdisciplinary provision of services and the creation of residents' individualized plans.	*Areas in which Less Oversight is Necessary* ▪ *With regard to routine and preventative care, at the time of the January 2012 review, BSDC continued to use their Annual Healthcare Screening tool in line with nationally recognized standards. In conjunction with ongoing review by BSDC medical professionals, this tool was used to ensure routine and preventative medical care was provided based upon diagnosis and age. Based on record review, rates for the completion of routine and preventative care or adequate justification for not completing it was between 88 and 100%.* ▪ *BSDC's policy for acute/emergency healthcare continued to be to use community emergency care and local hospitals. Appropriate action was noted for incidences where individuals were in need of emergency care.* *Note: Neurological care is addressed with regard to Sections D100 through D104, and interdisciplinary provision of services is addressed in relation to Section D93.*
Adequate Health Care Staffing		
D91	The State shall maintain sufficient numbers of adequately trained health care staff, including physicians and nurses, on each shift to provide adequate protections, supports, and services to residents at all times. The State shall take effective steps to reduce reliance on temporary or floating health care staff, who may not be as familiar with the particular needs of individual residents. The State shall place a heightened focus on ensuring that new and temporary floating health care staff are properly trained on individualized resident	*Areas in which Less Oversight is Necessary* ▪ *Based on the January 2012 review, BSDC had continued to maintain steady medical and nursing staffing appropriate to support the care of individuals. The Director of Nursing position had been filled. An Acting Medical Director was in place, as well as a staff physician and three full-time nurse practitioners.* ▪ *BSDC continued its use of part-time onsite psychiatrists, as well as the use of tele-medicine options. BSDC had continued its onsite Spine and Gait Clinic. Dental care service continued to allow for care to be provided under anesthesia for individuals who would otherwise not tolerate the needed treatment.* ▪ *Generally, temporary and/or floating staff were not used. To cover the couple of nursing vacancies, overtime was used as opposed to temporary staff, who would not be familiar with the individuals. In addition, during times when coverage was needed due to vacations and sick leave, existing staff reportedly provided vacancy coverage to maintain consistency. BSDC continued to maintain a model in which there were five different residential units (i.e., ICFs/ID) on campus with defined staff and services. Staff were being assigned to one ICF/ID. This reportedly allowed staff to become familiar with the individuals in their assigned unit, resulting in less opportunity for untrained staff to be working in the homes. Nursing also was moving to a model of assigning*

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	needs before assignment to any particular unit.	*nurses to each of the five ICFs/ID. However, at the time of the review, the 11 p.m. to 7 a.m. shift continued to have nurses floating between ICFs/ID, at times, but work was continuing to eliminate this practice.* *Note: Training of nursing staff is discussed below with regard to Section D114.*
Medical Care		
Health Care Assessments, Diagnoses, Treatments, and Follow-Up Monitoring		
D92	The State shall have a physician conduct comprehensive health care evaluations of all residents, and repeat at annual intervals unless required more frequently by each resident's condition. The assessments shall be sufficient to enable the physician to reach a reliable diagnosis, if applicable, for each resident. The State shall develop and implement a system to ensure that referrals and testing procedures are completed and results are placed in the residents' medical record in a timely manner. For each resident assessed as having a health care concern or concerns, a physician shall document a clinically justifiable health care diagnosis for each of the resident's conditions. Based on the comprehensive medical assessment, the State shall ensure that a physician develops for each resident an integrated health care plan to address any health care conditions revealed through the assessment process. The State shall ensure that each resident's health care plan is implemented	*Areas in which Less Oversight is Necessary* ▪ *Based on record review, rates for the timely completion of healthcare evaluations in the form of Annual History and Physical (H and P) were over 90%.* ▪ *The State had developed and was in the process of fully implementing an electronic system (Avatar) to ensure that referrals and testing procedures were completed and the results were available in a timely manner. Record review showed that this had occurred for all individuals in the sample.* *Areas Requiring Focused Effort* ▪ *Note: This also relates to Section D110. With regard to the development for each individual of an integrated health care plan to address any health care conditions revealed through the assessment process and ensuring the health care plan is implemented properly day-to-day to meet each individual's health care needs, BDSC staff indicated that the Nursing Care Plan was used to educate staff and ensure implementation of required treatments and interventions. Further, the Nursing Care Plans reportedly were derived from the Medical Problem List, as well as the H and P. Areas of focus should include ensuring nursing care plans include appropriate treatment plans and monitoring mechanisms related to a individual's diagnoses, including clear definition of the supports related to individuals' health care needs that nurses and direct support professionals need to provide, and competency-based training for staff to ensure appropriate implementation of such supports.* Psychiatry and psychology undertook a series of Diagnostic Review meetings in order to bring psychiatric diagnosis in line with DSM-5. A request for documentation of all such meetings over the previous six months indicated that 53 individuals had been reviewed. BSDC nursing and medical staff continued to report use of the H and P, as well as the Nursing Care Plans to educate direct support professionals, as well as to provide a resource for direct support professionals on a daily basis as they provided care to individuals they supported. Integration of six Healthcare Coordinators (LPNs) under the direction of the ICF Administrators and clinically supervised by the DON was reported to have been completed last year. The current DON and

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	properly, day-to-day, to meet each resident's individualized health care needs.	Medical Director reported that the Healthcare Coordinators continued to play a pivotal role in ensuring appropriate, quality care is provided. The Healthcare Coordinators completed a random review of the direct support professionals' understanding of individuals' nursing care plans. In order to provide feedback on the most recent nursing care plans, the Independent Expert Team requested sample of nursing care plans with documentation supporting competency-based education on plans for direct support staff. Nursing care plans the Independent Expert Team reviewed included those for Individual #197, Individual #208, Individual #192, Individual #55, Individual #201, Individual #326, Individual #359, Individual #268, Individual #384, Individual #296, and Individual #251 showed individualized and meaningful care strategies. In addition, documentation was provided showing competency-based education of these plans for the direct support staff. The revised nursing care plan format clearly delineated the Direct Service Professionals' responsibilities in care delivery. The DON reported that as of March 31, 2014, the newly revised nursing care plan format had been implemented for all 126 individuals residing at BSDC. In addition, the DON reported that any time changes were made on a nursing care plan this information was shared with the IDT and training was provided to the direct support staff regarding the change(s).
D93	To assist implementation efforts, the State shall take effective steps to improve communication among disciplines and departments at BSDC to eliminate confusion and fragmentation of care. To assist with this, the State shall continue to require medical staff members, including physicians and nurses, to participate in interdisciplinary team meetings. In addition, the State shall take effective steps to simplify and streamline charting, documentation, and record-keeping, with a goal of enhancing interdisciplinary communication and coordination to enhance timely service-delivery and continuity of care.	*Areas in which Less Oversight is Necessary* ▪ *Note: This also relates to Section D90. With regard to interdisciplinary meetings, based on review of documents, observations, and interviews, increased medical staff presence was noted at scheduled IDT meetings, and many "special" IDT meetings requiring medical presence. The BSDC Acting Medical Director indicated that all IDT meetings were coordinated through the medical staff secretary to assist in ensuring medical staff's participation at these meetings.* *Areas Requiring Focused Effort* ▪ *As noted with regard to Section C84, an area in which continued work was necessary included the need for better coordination of care between psychiatrists and other medical providers and/or members of the treatment team, particularly neurologists.* ▪ *An area in which BSDC was actively working was on the coordination between nursing/medical staff and residential staff. In January 2012, the new Acting Medical Director had just put a process in place to have regular meetings between these groups. However, more time was needed to evaluate its effectiveness.* ▪ *With regard to recordkeeping, an area requiring focus was on improving provider (MD, Nurse Practitioner) documentation regarding ongoing coordination of care, as well as communication with other disciplines. Based on the January 2012 review, for periods of up to three months or more (as the records provided only contained three months of clinician progress notes), no entries from medical providers were found, while a myriad of testing, treatment changes, consultation and care had occurred. On a regular basis, no consistent documentation was found of*

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		communication with outside practitioners, nor commentary on change in treatment related to testing or change in status, nor updates on general health. At times, this made it difficult to follow the chronology of care and to discern whether all care was being provided. ▪ *In addition, with regard to psychiatric notes, in a number of the Monitoring Team's reports, it had been noted that numerous errors were found in psychiatric notes. Some of the resultant errors were insignificant. However, some had the potential to impact psychiatric care of the individuals by leading to confusion, and sometimes the errors made it impossible to ascertain what psychopharmacologic choices were being made.* <u>Medical Records</u> Prior reports described problems, at times, with information BSDC was providing to subspecialty consultants. To review this, three consultations were formally reviewed. For three individuals from BSDC who had needed subspecialty consultation, the following data were reviewed: medical notes for the three months prior to and subsequent to the consultation; all laboratory studies in that period; the most recent history and physical examination prior to the consultation; forms provided to the consultant prior to the consultation; and the consultant's report. In all three of these cases, necessary information was provided to the consultant: ▪ On 12/5/13, Individual #411 was seen in follow-up by his cardiologist to check on the status of his sinus tachycardia (high pulse rate). The BSDC nurse practitioner provided the consultant with sufficient information to make an informed decision as to the next course of action (which was to continue the individual on the medication the cardiologist had previously started). ▪ In early 2014, Individual #94 was seen several times by her podiatrist in follow-up of surgical repair of her hammertoe. The course of recovery was complicated by her self-removing a stabilizing pin and developing a local skin infection. The BSDC Nurse Practitioner provided the podiatrist with adequate information for his decision-making. ▪ In late 2013, Individual #48 was evaluated for her variable appetite and weight loss. She was referred to a consultant for medical work-up where a diagnosis of gall bladder disease was made and her gall bladder was subsequently surgically removed. Adequate information was provided to the surgeons. With regard to the accuracy of records and documentation of follow-up, three records of BSDC residents reviewed to assess the quality of the information provided to guardians showed some confusion with regards to plan follow-up or other documentation issues: ▪ As described above, Individual #47 was being given Depakote, Zyprexa, and Trazodone. His psychiatric notes described him as having some sedation, varying from apathy to fatigue, which the psychiatrist reasonably ascribed to the individual's psychiatric medication regimen. He also had problems with mild low white blood cell counts and platelet counts, reasonably ascribed by the psychiatrist to the Depakote. This concern was clearly articulated in his 10/29/13 note, when the psychiatrist wrote: "I am particularly concerned about the use of Valproic Acid

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		[Depakote] given his pancytopenia [low blood counts] and note that our primary care provider notes that there was a modest increase in his blood counts across the board when it had been discontinued." The psychiatrist described a plan to review the individual's record and look for an alternative mood-stabilizing agent, which would allow withdrawal of the Depakote and potentially the Zyprexa. This plan was not mentioned in the subsequent note, from 1/29/14, where a plan was set up to consider a reduction in the Zyprexa at the following appointment. While some blood test results from 1/27/14 were described in that note, the fact that his Depakote level had increased to the high level of 114.7 was not mentioned. At the next appointment, on 2/26/14, the prior plans to look to alternative mood stabilizers or decrease the Zyprexa were not mentioned. That note described a plan to decrease the Depakote at the next meeting, if the individual remained behaviorally stable. While the suggested plan seemed reasonable, it was not clear why the changes in prior plans were not addressed. ▪ The plan for Individual #378 described in his 12/5/13 psychiatric note was to see him in a month and "if we have another month of well-preserved sleep and no significant manic behaviors, we will look at a modest reduction in the chlorpromazine." While he in fact had met these behavioral benchmarks as of the 12/31/13 appointment and at the subsequent 1/31/14 appointment, medications were not changed, and the fact that there had been a change in plans was not mentioned. As described above, the guardian was quite upset at that 12/31/13 meeting that medications were not reduced. An error also was noted in the individual's 12/31/13 note. That note stated: "...since the discontinuation of the Zyprexa, we have seen the normalization of the blood sugars... and most recently have received the encouraging news that his Hgb A1c [a measure of the state of his diabetes] has dropped to 6.0 [a normal value]." The note did not mention that, while his blood sugar dropped temporarily after the Zyprexa was stopped, it subsequently increased again, requiring the initiation of a medicine for diabetes, Metformin, on 11/4/13. The Metformin (probably the reason his blood sugar had returned to normal) was listed as one of his current medications in that 12/31/13 note. ▪ As noted with regard to Section C83 of this report, Individual #282 had multiple medication changes. It was unclear from the psychiatric notes when the antidepressant Citalopram was stopped. His psychiatric note of 11/21/13 listed one of his current medications as 40 mg of Citalopram. There was no mention in the note of a plan to adjust this dose downwards. The note from the next contact, on 12/19/13, had a plan for various medication changes, but an adjustment of his Citalopram dose was not one of them. The next psychiatric note no longer listed Citalopram listed as a current medicine. There was no comment in the body of the note that that medication had been discontinued. It was also not listed as a current medicine in documents from his 1/2/14 emergency room visit (when he was evaluated for having swallowed some batteries). According to the BSDC Medication Profile (undated, but after 2/27/14), Citalopram had been stopped, though the date it had been stopped was not mentioned. Page one of the psychiatric note of 12/19/13 was not provided for review (the remainder of the note was provided). Perhaps there was some discussion of the Citalopram

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		having been stopped on that page. As has been detailed in some of the Independent Expert Team's previous reports, the Facility had taken a number of steps to improve communication between the members of the medical team, and between the medical team and consultants as well as residential staff. As noted above, some work was still needed to ensure documentation was correct, and necessary follow-up occurred and/or was documented.
D94	The State shall have a physician determine what specialized health care services, including neurological services, are required for each resident and ensure that each resident receives such specialized health care services in a timely manner whenever necessary to evaluate or treat each resident's health care problems.	*Areas in which Less Oversight is Necessary* ▪ *Based on the January 2012 review, in most circumstances, it appeared that referral to specialized healthcare services was consistently completed within the sample of records reviewed.*
D95	The State shall develop and implement an effective system to regularly monitor each resident's health status and progress and develop and implement changes, whenever warranted, in each resident's health care plan. The State shall establish a health care quality assurance program that actively collects data relating to the quality of health care services, assesses these data for trends, initiates inquiries regarding problematic trends and individual issues, identifies and triggers corrective action, and provides ongoing monitoring to ensure that appropriate remedies are achieved.	*Section D96 is also addressed here, because chart/record reviews are part of a "health care quality assurance program."* *Areas in which Less Oversight is Necessary* ▪ *Based on review of documentation and staff interview, BSDC had an ongoing system for internal record audits, including three random reviews per month completed by medical staff, and five random reviews per month completed by nursing supervisors. The tool currently being used by Medical staff to audit/review was adequate. Concerns related to the auditing of nursing records are addressed with regard to Section D113.* ▪ *Attention to closing the loop between medical audits and necessary corrective actions was apparent. In a sample of five random medical audits, five of five records reviewed (100%) included evidence of review and corrective action for the concern(s) noted.* ▪ *Based on interview and document review, monthly review, trending, and analysis of BSDC medication errors was occurring. This information was brought to the overall BSDC QA Team for review. In most cases, the actions taken to follow-up with regard to medication errors was staff retraining (Medication Aide and Nursing), as applicable.* *Areas Requiring Focused Effort* ▪ *During the January 2012 review a new process was presented that allowed trending of data from the internal audits to identify problem areas, analysis to assist in defining corrective actions*

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		needed, and identification of follow-up activities to ensure the effectiveness of the corrective actions taken. The aggregation of data gained from these reviews, as well as a refined system for trending and analyzing data continued to be in the initial stages of development and implementation. ▪ *At the time of the January 2012 review, the Facility presented a plan for finalizing its outcome measures/key indicators, including a time line. Efforts necessary to finalize and implement this process are discussed with regard to Section A14. Essential to the implementation of this system is demonstration that it "assesses these data for trends, initiates inquiries regarding problematic trends and individual issues, identifies and triggers corrective action, and provides ongoing monitoring to ensure that appropriate remedies are achieved."* As noted with regard to Section A14, efforts had been undertaken to further integrate the medical and nursing QA processes with the larger QA/QI system.
D96	The State shall develop and implement a plan to conduct regular internal chart audits with regard to the delivery of effective health care to residents. If any problems or concerns are identified as a result of any audit, the State shall promptly develop and implement corrective measures, both for individual and systemic issues.	*This section has been incorporated with Section D95.*
Priority Group		
D97	Based on the assessments and the monitoring, the State shall create a list of health care priority residents for heightened and enhanced attention and focus. This priority group shall consist, at least, of those residents who have had a seizure or have a seizure disorder, have developed or are at risk of developing a bowel impaction or bowel obstruction, have aspirated or are at risk of aspirating, have	*Areas in which Less Oversight is Necessary* ▪ *Review of documents and interviews with staff substantiated the maintenance of a list of priority individuals based upon the criteria set forth in the Settlement Agreement, as well as additional criteria that BSDC established. Medical, nursing, and other specialty staff created an updated 27-question tool from which a weighted score could be calculated to determine the relative significance of the condition. Documentation dated January 2012 showed that BSDC had collected data on all individuals. Scoring had been completed for each individual. Updates to the risk scores were presented with some changes noted from medium to high-risk scores for some individuals.*

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	developed a decubitus ulcer or skin breakdown or are at risk of developing a decubitus ulcer or skin breakdown, and have suffered a fracture or are at risk of suffering a fracture, including those residents with osteoporosis. The State shall include in this priority group any other resident who is in an at-risk group or is at-risk of suffering an incident that would adversely impact his or her health.	
D98	In close consultation with outside consultants, as appropriate, the State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, that meet the residents' individualized needs. The intent is that the State will develop and implement strategies to provide proactive health care such that resident seizures, bowel impactions and obstructions, aspiration and aspiration pneumonia, decubitus ulcers and skin breakdown, fractures, and the adverse consequences of other at-risk conditions will be minimized or eliminated.	*Due to Section D99 being tied directly to the requirements in D98, the two have been combined.* *Areas Requiring Focused Effort* ▪ *Although from a medical perspective, based on a sample of records, treatment generally appeared to be in place for individuals in the priority group, this requirement encompasses the full array of protections, supports and services to meet individuals' needs. Based on concerns related to nursing care plans, and direct support professionals' knowledge about their roles in providing supports, monitoring and reporting signs and symptoms of specific diagnoses, etc., this was an area that required additional effort. As noted with regard to Section D92, areas of focus should include ensuring nursing care plans include appropriate treatment plans and monitoring mechanisms related to a individual's diagnoses, including clear definition of the supports related to individuals' health care needs that nurses and direct support professionals need to provide, and competency-based training for staff to ensure appropriate implementation of such supports.* BSDC had continued to make use of their established risk scoring tools as well as triggers. In review of the records provided specific to the medical and nursing care provided, individuals appeared to have been screened for "intensive protections" and processes were noted to monitor for and manage care. Care plans examined during this review for Individual #201, Individual #192, Individual #221, Individual #296, and Individual #102 were found to have been individualized, and clearly identified treatment for condition, who was to provide care and or monitoring, as well as outcomes expected. These results are consistent with what the Independent Expert Team found during the previous review. In addition, BSDC has implemented a peer review/chart audit on a monthly basis. During these reviews, nurses randomly reviewed charts of individuals that were not in his/her service area to assess the care plans and comprehensiveness of care delivery.

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D99	The steps necessary to achieve such positive outcomes for the residents in this priority group may include daily interdisciplinary team meetings, regular contact with outside consultants, as appropriate, close observation of the residents and their staff, daily competency-based training of staff with regard to how to properly implement needed interventions, regular revision of plans and approaches, and changes in the living environment.	*This has been addressed above with regard to Section D98.*
Seizure Disorders		
D100	The neurologist(s) shall identify all residents currently receiving anticonvulsant medication, residents with an existing diagnosis of epilepsy, and residents who have had at least one seizure in the past two years, and provide them with a comprehensive evaluation using a detailed diagnostic work-up conducted by a neurologist, at least annually, or more frequently as required by each resident's condition.	*Areas in which Less Oversight is Necessary* ▪ *Based on a sample of records, individuals with seizure disorder were provided routine neurological care. At the January 2012 review, neurology needs were being met by onsite practitioners, as well as established community providers.*
D101	The neurologist(s) shall ensure that those residents with refractory seizures, i.e., those having more than 10 seizures in one year, receive appropriate and effective neurological interventions.	*Areas in which Less Oversight is Necessary* ▪ *Based on a review of records for individuals with refractory seizures (i.e., more than 10 in one year), all appeared to show evidence of "appropriate and effective neurological interventions." Neurology, Medical, and Psychiatry staff had increased communication with regard to effective management of refractory seizures. Consultations related to proper treatment and management of individuals' seizure disorders were noted. During the January 2012 visit, neurology staff as well as the Medical QA Nurse indicated regular use and trending of seizure data as part of individuals' treatment regimens. The neurology team reported that they had access to the seizure frequency provided through monthly tracking, as well as type, duration, and status change. BSDC Neurology*

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		staff had continued also to focus on reduction of both seizure frequency, as well as type and dosage of antiepileptic drugs.
D102	The neurologist(s) shall document the rationale and need for anticonvulsant medication in all cases, with a special emphasis on those residents receiving anticonvulsant polypharmacy, and document whether the potential harmful effects of the anticonvulsant medication on a resident's quality of life outweigh the potential benefits of the use of the medication. The neurologist(s) shall ensure that it is still appropriate for each resident currently receiving anticonvulsant medication, but who has remained seizure-free for the past two years, to continue to receive the anticonvulsant medication. For each resident receiving medications for both seizures and a mental health disorder, the psychiatrist(s), the neurologist(s), and the interdisciplinary team shall coordinate the appropriate and continued use of such medications. The use of intra-class polypharmacy shall be minimized, and whenever it is used, the neurologist(s)/ psychiatrist(s) shall fully justify its use in that resident's treatment plan.	*Areas in which Less Oversight is Necessary* ▪ *Records reviewed included a documented rationale for treatment.* ▪ *As applicable, all records reviewed showed ongoing discussion and action in regards to the reduction of anticonvulsant polypharmacy medication therapy. Discussion regarding reduction and or change to medication therapies shown to have fewer side effects was noted in all cases.* *Areas Requiring Focused Effort* ▪ *As addressed with regard to Section C84, an area in which continued work was necessary included the need for better coordination of care between psychiatrists and neurologists.* Given the progress noted during the last review of BSDC in September 2012, the Independent Expert Team recommended less oversight for this provision. As a result, it was not included in the most recent review.
D103	The State shall develop and implement a system that ensures the accurate and timely recording	*Areas in which Less Oversight is Necessary* ▪ *Evidence of implementation and use of documentation to track and describe seizure events was noted in records reviewed, as applicable. Standardized tracking tools were used and included*

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	of seizures for each resident including the following information: the date and time of the onset of the seizure; the duration of the seizure; a description of the seizure; an indication as to whether or not the resident is conscious or unconscious; if unconscious, the onset of the unconsciousness and the duration of the period(s) of unconsciousness; any medical or other steps taken to control the seizure; and the resident's response to the intervention. All staff, including nursing and direct care staff, shall be provided with competency-based training in recognizing a seizure, describing the seizure and length of time it lasts, and recording that information in the resident's record.	*most of the information the Settlement Agreement requires, including in the Seizure Record: date and time of onset of the seizure, duration of the seizure, and description of the seizure with check offs; and in the Physicians' Orders/Clinician's Progress Notes: medical or other steps taken to control the seizure, and individual's response to these actions. Based on the Settlement Agreement requirements, loss of consciousness was not included, but lack of responsiveness was. Adding duration to the lack of responsiveness section would address all of the required components.* ▪ *Documentation provided during the January 2012 review showed ongoing training regarding general seizure activity, as well as individual seizure protocols/needs or emergency plans.*
D104	The State shall develop and implement an emergency protocol for the proper treatment of status epilepticus and provide competency-based training to the staff on how to implement it.	*Areas in which Less Oversight is Necessary* ▪ *Based on review of records, individuals had Seizure Needs plans and associated documentation of staff competency-based training in place, as appropriate. The Seizure Needs plans had information related to addressing status epilepticus, which generally was adequate.*
Peer Review		
D105	On or before January 1, 2009, the State shall create a peer review system with regard to the provision of health care services to residents. The peer reviewers shall be independent and external to BSDC and shall include individuals who are not employees of the State	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January 2012 review, BSDC had completed its last peer review with The Columbus Organization in April 2011, and had responded to all suggestions and commentary. Although a delay had occurred with this review, it had been completed and provided valuable information.* ▪ *Evidence of continued work to address issues that the external peer review process had identified as requiring attention was provided and/or discussed with key staff.*

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	Department of Health and Human Services. The peer reviewers shall be well-respected health care consultants who have a demonstrated history of effectively meeting the health care needs of persons with developmental disabilities. Peer review of the provision of health care shall take place at least once a year. The peer reviewers will review a limited sample of plans from each physician or other primary health care provider. The review will include a targeted review of plans for residents in the health care priority group. Promptly after each peer review, the State will develop and implement measures to address all individual and systemic issues identified in the peer review process.	
Mortality Reviews		
D106	On or before November 1, 2008, the State shall create an independent and external mortality review committee, comprised of well-respected health care consultants who have a demonstrated history of effectively meeting the health care needs of persons with developmental disabilities. The members of the mortality review committee shall be independent and external to BSDC, and shall not be employees of the State Department of Health and Human	*Areas in which Less Oversight is Necessary* ▪ *With regard to an external Mortality Review Committee (MRC), the State had external MRCs working towards completion of past and present mortality reviews of individuals that had lived at BSDC as of November 19, 2007. This included individuals who continued to reside at BSDC at the time of their death, as well as those who had transitioned to the community. The external MRCs' existence continued to be confirmed through documentation. These groups appeared to have professionals who met the criteria for qualifications and experience as required by the Settlement Agreement.*

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	Services. The consultants who serve on the mortality review committee may also serve on the health care peer review committee. The purpose of the mortality reviews is to identify and promptly resolve any preventable causes of illness and death so that other similarly situated residents will not suffer preventable illness or death.	
D107	The mortality review committee shall meet promptly after each resident death to address individual and systemic issues related to each death. The committee shall have full and complete access to pertinent health care records and other documents, physicians and primary health care providers, and staff. The committee shall conduct appropriate interviews, and review and discuss any necessary supporting documentation related to the course of care leading up to each death, including: the death incident report, the completed death investigation, documents from the resident's chart, any autopsies that may have been performed, and reviews from all pertinent disciplines.	*Areas in which Less Oversight is Necessary* ▪ *Overall, improvement was seen regarding timely MRC review, as well as the State's response to external mortalities reviews. At the time of the January 2012 review, with exception of one case, the reviews of individuals who had passed away were completed within six months or less, inclusive of BSDC's response. Although improved, to maintain this status, attention will be needed to ensure MRC reviews are completed in a reasonable time period.* ▪ *Of the completed reports that the External Mortality Review Committee produced, it appeared that the Committee reviewed all of the necessary documentation, and made the necessary staff contacts to thoroughly investigate and support any recommendations made.*
D108	The committee shall identify preventable causes of illness and/or death, if any, in each individual case. The committee shall make written	*Areas in which Less Oversight is Necessary* ▪ *The MRC reports clearly reflected any preventable causes of death, as well as recommendations for remedial action.* ▪ *Of the completed external mortality committee reports provided at the time of the January 2012 review, BSDC had responded to all recommendations. In the past, BSDC had responded to certain*

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	recommendations for remedial action, whenever appropriate, with regard to individual and systemic issues related to the death. The State shall ensure the prompt and effective implementation of all of the committee's recommendations. The mortality review committee shall continue to monitor all recommendations for remedial action until they are implemented.	*recommendations by stating "we are in agreement" or "this is now in place." BSDC's more recent responses included more substantive written response with examples of supporting documentation attached.* *Areas Requiring Focused Effort* ▪ *In addition to identifying concerns relevant to the death on which the Committee was reporting, the Committee also noted if this had been a concern in previous reports. Although this was helpful, it did not provide the view of "systemic issues" that the Settlement Agreement requires. However, after the January 2012 review, the State submitted a summary of the death reviews one of its contractors completed in 2011. This was a helpful report that summarized a number of trends and made some systemic recommendations. The State's response was not included, and, as discussed during the Monitoring Team's April 2012 review, the State did not yet have a methodology for sharing relevant recommendations with community providers supporting individuals that resided at BSDC as of October 19, 2007.* ▪ *Based on documentation provided, it was not clear that the MRCs were continuing "to monitor all recommendations for remedial action until they are implemented."* Mortalities are discussed above with regard to Section B48.
National Health Care Organizations		
D109	The State shall take effective steps to encourage health care staff to become more actively involved in national health care organizations, especially those that focus on providing proactive health care to persons with developmental disabilities. The intent of this provision is that more involvement and engagement with national health care organizations may lead to better health care for residents.	*Areas in which Less Oversight is Necessary* ▪ *BSDC healthcare staff continued to be offered membership to applicable discipline-based organizations. Organizations that focus on the provision of proactive healthcare to persons with disabilities provide a much-needed opportunity for health care staff to gain vital insights into care delivery, new treatments, and strategies to address the specific needs of individuals with developmental disabilities.*
Nursing Care		
D110	The State shall provide residents with adequate, appropriate and timely nursing care to meet the individualized needs of the	*Nursing assessment (i.e., "identifying and assessing healthcare problems") is addressed with regard to Section D111.* *Nursing Care Plans (i.e., "developing and implementing appropriate interventions") are addressed with*

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	residents. Nurses shall perform their responsibilities by adequately identifying and assessing health care problems, developing and implementing appropriate interventions, monitoring and intervening to ameliorate such problems, evaluating the appropriate outcome for the problems, and keeping appropriate records of residents' health care status.	*regard to Section D112.* *"Monitoring and intervening to ameliorate such problems" and "evaluating the outcome for problems" are addressed in relation to Section D113.* *Areas Requiring Focused Effort* ▪ *With regard to keeping appropriate records of residents' health care status, the issues of documenting by exception as well as inconsistency with the documentation format were problematic. Because nurses were documenting in nursing notes only when a significant change in health occurred or physicians' orders were updated, important information was missing. Situations where individuals with significant healthcare needs had no nursing note documentation for several weeks at a time were noted. Ongoing documentation needs to be maintained of assessment and care in relation to the various nursing care plan elements and needs of the individuals. Such documentation should provide a picture of the individual's ongoing status with regard to their healthcare issues to the various shifts of nursing and other staff working with the individual.* ▪ *Nursing documentation also needed to consistently include the required elements and detail to provide adequate information to other staff responsible for the individual's care and treatment.* ▪ *Although Subjective, Objective, Assessment, Plan (SOAP) notes were presented as the BSDC standard for nursing documentation, review of records showed inconsistent or no use of the SOAP format. The Director of Nursing was aware of this issue, and indicated that revamping the Nurse Practice tool and retraining nursing personnel on it was expected to alleviate this issue.* Adequate and Timely Nursing Care and Assessment Since the last review, BSDC utilized the services of a consultant nurse to provide extensive training for all nurses related to documentation, including nursing assessments, nurses' notes, and nursing care plans. The sample of individuals the Independent Expert Team reviewed included appropriate nursing assessment tools, flow sheets, and tracking records, in addition to the nursing notes and care plans. Each time a health issue arose, a nursing note was written and changes were made to the care plans, when indicated. In addition, a system now existed to have a weekly nursing note written in response to at least one-quarter of the nursing care plans. Each week another section of the care plan was included in the nurse's note, so that at a minimum, on a monthly basis, each part of the care plan was addressed, even when the individual's health remained stable. In December 2013, a comprehensive revision of the *Nurse Practice Manual* was completed. Policies regarding nursing documentation and the frequency of nurses' notes were now in place. Based on the Independent Expert Team's review, examples of charting nurses completed before the documentation training and examples of charting done after the documentation training showed significant improvement.

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		In addition, an expanded quality assurance system had been implemented at BSDC, including a monthly peer review/chart audit, a monthly MAR audit of each individual's medications, and a quarterly pre-IPP meeting and completion of audit form for each individual on campus. Each of these was an important component of a QA system to ensure that an individualized and comprehensive approach is being utilized to best meet each person's needs. For the monthly peer review/chart audit, a nurse reviewed a chart on a different unit than the one he/she is working on. This was helpful to have another nurse look objectively at the chart, and raise questions that might have otherwise been overlooked. A monthly MAR audit of each individual's medications was important to ensure accuracy with the physician's orders, and to determine if medications were being given and signed off appropriately. The quarterly pre-IPP meeting review offered an opportunity to ensure documentation is present to show all current health needs have been addressed appropriately in the nursing care plan and that all physician orders have been implemented. From this audit, the nurse attending the IPP is able to give an accurate update about the health status of the individual. In summary, it appeared BSDC currently had a comprehensive, workable system in place to ensure that nurses were documenting accurately and completely. As long as periodic updates and reviews of documentation policies are conducted for current staff, and comprehensive orientation and trainings are conducted for new employees, a positive impact should be seen for the quality of care for individuals.
D111	The State shall develop and implement policies to guide the delivery of nursing care to meet the residents' needs with regard to conducting assessments, frequency of follow-up, and documentation for changes in residents' health status. The State shall develop and implement policies that require nursing participation in the interdisciplinary provision of services and the creation of individualized nursing care plans as part of residents' individualized plans. Nurses shall participate as core members of the interdisciplinary team. These	*Areas in which Less Oversight is Necessary* ▪ *Monthly summaries on the nursing care plans, as well as quarterly nursing evaluation and assessment reports generated by primary nurses with assistance of nursing supervisors were generally found. Where concerns were noted, as identified below, was in relation to the Nursing Care Plans adequately defining what was assessed, and the frequency of assessment/follow-up.* *Areas Requiring Focused Effort* ▪ *Although BSDC had policies related to the provision of nursing care, the policies or systems in place to ensure ongoing monitoring of daily care as well as communication with "all team members" regarding any assessed or diagnosed change in care required strengthening and/or full implementation. Clarification was needed in policy and/or procedures/protocols with regard to the systems and tools that would be used to drive daily care of individuals supported at BSDC. For example, a disconnect existed between the Nursing and Residential Departments with regard to what tools were being used to educate all staff (nursing and residential) about, and ensure integrity and consistency in the implementation of daily care.* ▪ *Improvements were needed with regard to the integration of the Nursing Care Plans with the IPPs. This included the need for a more interdisciplinary approach to reviewing, modifying as necessary, and finalizing Nursing Care Plans.*

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	policies shall include a formal communication system to alert all team members and health care providers to changes in a resident's health status, and documentation of reasons for the discontinuation of any team recommendations.	▪ *In order to ensure that nurses were regularly assessing individuals adequately, Nursing Care Plans required improvement. Because Nursing Care Plans drive assessment, monitoring, and treatment of conditions, missing diagnoses in individuals' Nursing Care Plans were factors in missing nursing assessments in the daily documentation. Section D112 more fully addresses nursing care plans.* ▪ *At the time of the January 2012 review, "a formal communication system to alert all team members and health care providers to changes in a resident's health status, and documentation of reasons for the discontinuation of any team recommendations" was still being developed.* In the last report related to BSDC, improvement was seen with regard to integration of nursing care plans in IPPs, the completeness of nursing care plans and communication between disciplines regarding nursing assessment. Focused efforts are needed on an ongoing basis to ensure that changes of status are identified, addressed, and communicated to team members. Examples of improvements in this area are that nurses now sit down with the Nurse Practitioner each quarter for each individual for a pre-IPP review/audit. This is a time when the health status and supports are carefully reviewed to ensure that the nursing care plans are consistent with the individuals' current health status and that physicians' orders are current and have been implemented. The nurse attending the IPP can then give an accurate report based on the information generated at the pre-meeting. <u>Nursing Care Plans</u> During this review, Nursing Care Plans for eleven individuals were reviewed that had been completed or updated during the past three months. They all used the updated format in which the direct support professionals had a separate column to delineate their roles in implementing care. Significant improvement was noted in the care plans since the mandatory training was done for all nurses. Creating a column for the direct support professionals outlining their roles in the implementation of the nursing care plan strengthened the rationale for daily care and the importance of appropriate and complete documentation. IDTs continued to be utilized to discuss changes in an individual's status. Nursing was present and routinely participated in the IDT process.
D112	Nursing interventions shall be developed and implemented whenever needed, and especially for the following situations: (a) when a resident sustains an injury; (b) when a resident is restrained; (c) when medications are administered; (d) for the ongoing care of a resident's tracheotomy tube; (e) when a resident has a skin care and/or	*<u>Areas Requiring Focused Effort</u>* ▪ *Although improvements were being made, focused effort is needed to ensure that Nursing Care Plans include all applicable diagnoses where monitoring, assessment, and/or supports are needed. In addition, they then must detail the actions that will be taken for each of these diagnoses, the timeframes in which they will occur, and who will be responsible.* As previously mentioned, the eleven individuals in the sample had adequate Nursing Care Plans in line with the H&P as well as the medical problem list as per BSDC policy. Overall, the care plans were individualized and provided an understanding of needed daily care elements.

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	positioning and/or nutritional and physical management plan; (f) when a resident has or is at risk of developing a decubitus ulcer; (g) when a resident is at risk of a bowel impaction or obstruction; (h) when a resident presents any other risk factor; (i) when a resident suffers a significant weight loss/gain or is at risk of significant weight loss/gain; and (j) when a resident is enterally fed.	
D113	The State shall develop and implement an effective system to regularly monitor the residents' health care outcomes and make and implement changes in the residents' nursing care plans and interventions whenever warranted given the residents' needs.	*Areas Requiring Focused Effort* ▪ *Monitoring of healthcare outcomes is dependent upon using appropriate tools to monitor care, and allow for change based upon individuals' needs. BSDC's process for reviewing Nursing Care Plans was not robust enough to identify issues related inadequate initial plans. In addition, reviews were not consistently identifying issues with regard to elements of care not being provided on a day-to-day basis, daily data regarding each intervention or assessment being incomplete, ineffectively communicated, and/or not acted upon in accordance with the plan, applicable guidelines, and/or physicians' orders.* Monitoring of Healthcare Outcomes Procedures for the nursing supervisors (RNs) to have an expanded role in the creation and monthly review of nursing care plans appeared to be in place from review of documentation and sign-off of RN Supervisors. BSDC continued to report monitoring of Nursing Care Plans monthly, and additionally, at all scheduled and special IDT meetings, as applicable. Monitoring was inclusive of Primary Nurse (RN or LPN) documenting status of each identified Nursing Care Plan area (by associated data collection or absence of status change in area) and the Nursing Supervisor reviewing summaries. The primary nurse or nursing supervisor continued to be able to make changes to individuals' care plans as needed. The State reported their system to ensure that changes in care were communicated to all team members, especially to the level of the direct support professional, was through the Healthcare Coordinator positions. This system appeared to be functioning well.
D114	The State shall provide nursing staff with ongoing competency-based training with regard to the following: (a) appropriate	*Areas Requiring Focused Effort* ▪ *Although BSDC was providing training to nurses, it was not competency-based, as the Settlement Agreement requires. In addition, the specific areas the Settlement Agreement requires were briefly touched upon, but at the level of the direct support professionals, not licensed or registered*

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	documentation and description of a resident's status when the resident leaves the facility and upon the resident's return; (b) role of the nurse in the interdisciplinary team process; (c) functional programming and habilitation; (d) proper development and implementation of the nursing care plans; (e) proper documentation and treatment of decubitus ulcers, including the description and the stage of the ulcer; and (f) proper documentation and treatment of significant events.	*staff.* Nursing Ongoing Competency-Based Training As indicated in the Independent Expert Team's last report on BSDC, based on review of documentation and information gained through interviews, ongoing annual training for nursing staff was occurring at BSDC. The following reflected the training for nursing staff on modified nursing policies: ▪ Nursing Notification to DTSS When Medical Gives Orders Regarding Injury; ▪ Adapt to Data Action/Assessment Plan Documentation Format; and ▪ Diastat and Midazolam Administration. Of the competency training records reviewed, significant improvement was noted in the post-tests for the above listed training areas. The DON stated that if a failing score was obtained on the post-test, the nurse was required to re-take the class, and could not complete the procedure until a passing score was obtained. BSDC provided the Independent Expert Team with medical/health care training curricula for nursing and direct support professionals. An established online training resource with post-tests and tracking continued to be utilized. It was designed to enhance nursing education and close the gap on competency-based testing. In addition, during previous reviews, the implementation of the Lippincott Online Learning System to track education and document competency-based learning was reported. Based on information the Independent Expert Team requested for the current and past reviews, BSDC's nursing education was consistent with the components as outlined within the Settlement Agreement.
D115	The State shall develop and implement a nursing Performance Management Process to monitor nursing assessments and documentation. Where problematic trends are identified, the State shall timely develop, implement and monitor a corrective action plan given the residents' needs.	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January 2012 review, Nursing Supervisors were conducting three record audits per month per supervisor. The actual tool for auditing had been enhanced to include additional areas for commentary and review. During this review, the Director of Nursing presented a system for moving forward with tracking and trending of data revealed through the monthly audits, as well as a review and sign-off for corrective action following notice of variance. Initial data gleaned from the January 2012 audits noted appropriate analysis of trends and corrective action.* *Note: Given that at the time of the January 2012 review, a new system had been put in place to track and trend data resulting from the audits, and develop and confirm corrective action, during the next review, further analysis will occur of the newly enhanced systems.* For the past year, any reports generated by BSDC's health quality assurance program and any resulting corrective action plan, including information related to medical, dental, and/or nursing care are included in the following list:

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		▪ Medical Medication Error Reports ▪ Medication Error Action Plans ▪ Quality check of Avatar Orders against Medication Administration Record (MAR)/Treatment Administration Record (TAR) ▪ Fracture Reports ▪ Infection Control Reports ▪ Pharmacy and Therapeutic Reports Laxative and Prokinetic Therapy Antipsychotic Polypharmacy Antiepileptic Polytherapy ▪ Meaningful Use Report ▪ Teaching Components for Medication Aides and Nursing ▪ 2013 Indicators A12 Medication Error Rates A13 Medication Errors with Harmful Outcomes A17 Chemical Restraints A18a Rates of Medical Restraints A18b General Anesthesia A19 Medications for Behavioral Crisis Intervention B3 Dental Exam and Oral Hygiene B4 Hospitalization/ER Transfers B6 Rates of Pressure Ulcers B9 Rates of Pneumonia B10 Rates of Urinary Tract Infections B11 PCP Progress Notes B12 Laboratory and X-ray review B13 PCP Progress Notes/Outside Consultant B14 Inpatient Hospitalization B15 Informed Consent D9 Reduction of Psychoactive Medications due to Behavioral Improvement These reports were shared with administrators and then nursing managers who then shared the data with staff in order to address specific problem areas on each unit. For the last six months, any data summaries and/or quality assurance/enhancements reports used by BSDC related to nursing, including subsequent correct action plans are as follows: ▪ Medication Error Action Plans ▪ Fracture Reports ▪ Quality check of Avatar Orders against MAR/TAR ▪ Teaching Components of Med Aides and Nursing

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D116	The State shall administer medications to residents safely and effectively. When a medication error occurs, the State shall investigate the error, document it and take appropriate corrective action, including supervision and training.	*Areas in which Less Oversight is Necessary* ▪ *A medication variance/error tracking system continued to be in place at BSDC. The BSDC Medical QA staff person continued to receive all medication error reports, and tracked and trended them on a monthly basis. Monthly error reports were submitted to the BSDC QI Department, as well as Medical and Nursing Department heads.* ▪ *The primary focus of tracking continued to be medication variances related to potential or actual harm to the individual. However, the criteria for medication errors had remained the same (i.e., omission, dose, other, time, medication, patient, pharmacy, and documentation).* ▪ *Based on records reviewed, administration records and associated progress notes did not show any missed medications, missing initials of unexplained nature, or other variance.* ▪ *Documentation indicated that the action BSDC took to address these errors involved "Medication Aide additional training," and, in some cases, being "pulled from functioning" as a Medication Aide.* ▪ *The reports suggested BSDC had attained the quarterly goal of medication errors resulting in no apparent harm to individuals.* *Note: Given that at the time of the January 2012 review, a new system had been put in place to document corrective action following a medication error, during the next review, further analysis will occur of corrective actions associated with the newly enhanced systems.* Based on the findings from the last review of BSDC, the Independent Expert Team did not conduct further review of this area.
D117	The State shall ensure that nurses and other health care and direct care staff observe proper infection control procedures.	*Areas in which Less Oversight is Necessary* ▪ *BSDC included universal/standard precautions and infection control education as part of the core orientation curricula.* ▪ *The Facility also was noted to have appropriate hand washing and biological waste services available. In most cases, proper infection control (IC) practice was noted.* ▪ *The Facility had enhanced monitoring, surveillance, and trending of IC events, as well as an IC presence following any IC events to assist staff in proper management of conditions.* *Areas Requiring Focused Effort* ▪ *In order to ensure that infection control incidents are not missed, a clear listing or criteria for reportable infections should be made available to key supervisory or medical staff. The State reported that infection definitions had been adopted that should help provide needed guidance. The Independent Expert Team will review the new guidance and its implementation.* Given the progress noted during the last review of BSDC in September 2012, the Independent Expert

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		Team recommended less oversight for this provision. As a result, it was not included in the most recent review.
D118	The State shall develop and implement a policy on the proper procedure for emergency tracheotomy care and replacement that includes competency-based staff training. The State shall provide an adequate and appropriate replacement tube of correct size and length which is easily accessible to each resident with a tracheotomy.	*This requirement was no longer applicable. BSDC no longer facilitated emergency tracheotomy care onsite. Emergency tracheotomy care needs would require local emergency services or hospital care. At the time of the January 2012 review, no individuals residing at BSDC had tracheostomies. Should an individual require placement of a tracheostomy, a plan/policy would need to be developed.*
D119	The State shall develop and implement a protocol for documentation of caloric, protein, water, and/or fluid intake requirements to ensure that residents, including those who are enterally fed, are receiving the prescribed nutrition and fluid intake to meet their individualized needs.	*Areas in which Less Oversight is Necessary* ▪ *During the January 2012 review, standardized forms for documentation of intake and output were found in all applicable records reviewed. Additionally, during this review, enhanced dietary forms were in use that the PNMT created. Each individual in the sample had documentation of caloric intake needs in the form of Dietary Orders.* ▪ *With regard to individuals who were enterally fed, a form for enteral feeding orders was found in all applicable records reviewed. Review and modification of this form was completed quarterly, and, at times, more often, if there was a change in nutritional needs identified through the Nutritionist's assessment of laboratory results or change in weight. Nursing staff were responsible for all enteral feeding, and tracking continued to be on the Medication Administration Record.*

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

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Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - The following documents for five individuals (i.e., Individual #110, Individual #189, Individual #83, Individual #249, and Individual #61): PNCS Assessment/Action Plan, Point of Service plans, nursing care plan, Point of Service Treatment plan, and elevation assessment;
  - The following documents for seven individuals (i.e., Individual #164, Individual #186, Individual #162, Individual #191, Individual #156, Individual #153, and Individual #23): OT/PT assessment, IPP and IPP addendums related to OT/PT including attendance sheets, direct therapy program, skill acquisition program or other methods of generalizing direct therapy skills, documentation of staff training programs, and monthly progress notes for the past six months;
  - The following documents for five individuals (i.e., Individual #162, Individual #362, Individual #154, Individual #47, and Individual #186): therapeutic positioning programs and pictures, and OT/PT progress notes on positioning;
  - The following documents for 12 individuals (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #166, Individual #177, Individual #180, Individual #117, Individual #235, Individual #372, and Individual #366): SLP assessment, SLP direct therapy plan, IPP and IPP addendums related to communication including attendance sheets, skill acquisition program or other methods of generalizing direct therapy skills, documentation of staff training programs, monthly progress notes for the past six months, AAC Point of Service plans, and Positive Behavior Support Plans;
  - An organizational chart for BSDC;
  - An alphabetical list of all individuals served, including age, date of admission to Beatrice State Developmental Center, guardianship status, name of residence/home, and day/vocational program;
  - Physical and Nutritional Support (PNS) Procedures, May 2013;
  - Guidelines for the Home: 8.5 Enhancing the Mealtime Experience, dated 2/25/14;
  - A list of the current members of the Physical and Nutritional Consultation Support (PNCS) Team;
  - PNCS Scope, Risk Level and Entrance Criteria Procedure #PNS 1.0, revised 2/5/14 and 3/13/14;
  - A list of the current individuals supported by the PNCS Team, as well as identification of any individuals assessed by the PNCS Team and discharged by the PNCS Team;
  - Any policies and/or procedures that have been added and/or changed related to Physical and Nutritional Supports and the PNCS Team, and their dates of revision;
  - Point of Service template(s) and Dining Plan template, and instructions for completion;
  - Lists of individuals:
    - On modified diets/thickened liquids;
    - Whose diets have been downgraded (changed to a modified texture or consistency);
    - With body mass index (BMI) equal to or greater than 30 (including individual BMI);
    - With BMI equal to or less than 20 (including individual BMI);
    - Who have had unplanned weight loss of 10% or greater;
    - Had a choking incident, including individuals who received abdominal thrust;
    - Had an aspiration pneumonia and/or pneumonia incident;
    - Had chronic respiratory infections;
    - Had chronic dehydration;
    - Had a fecal impaction;
    - Who receive nutrition through non-oral methods;

        - Who are enterally nourished, but are receiving pleasure feedings;
        - Who have received a video fluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation;
        - Who use a wheelchair as primary mobility;
        - With transport wheelchairs;
        - With other ambulation assistive devices, including the name of the device;
        - With orthotics and/or braces;
        - Who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution; and
        - Who have experienced a fall(s), including name of individual, date, location, whether there was injury, and, if so, type of injury.
    - Schedule of meals by home;
    - Blank staff competency performance check-offs forms for:
        - Basic foundational skills in PNS; and
        - Individual-specific PNS training;
    - The number of staff responsible for the completion of each of the PNS foundational skills competencies, and for each, the number that have successfully completed the training, including the percentage completion;
    - The number of staff responsible for the completion of individual-specific competencies, and the number that have successfully completed the training, including the percentage completion;
    - Any summary reports or analyses of monitoring results related to the PNCS and/or individuals reviewed by the PNCS, and/or OT/PT/SLP supports generated by the Facility, including but not limited to quality assurance reports, as well as any follow-up action plans;
    - Any policies, and/or procedures related to the provision of OT/PT supports and services, if this has changed since the last review;
    - List of individuals receiving direct OT and/or PT services or therapy, and focus of intervention;
    - Maintenance log utilized by the Facility to track modifications made to individuals' adaptive/assistive equipment;
    - A list of individuals with Alternative and Augmentative Communication (AAC) devices (high and low tech), including the individual's name, residence, and type of device;
    - A list of individuals receiving direct speech services or therapy, and focus of intervention;
    - Copy of presentation presented at the National Occupational Therapy Association by members of the PNCS Team;
    - Handout showing decrease in respiratory illness;
    - List of individuals receiving therapeutic positioning;
    - List of individuals who have completed elevation assessment including PNS risk levels;
    - Nursing Care Plan Procedure (J.3), effective date 2/2014;
    - Tracker meeting documentation (spreadsheet) for Solar Cottages from Home Team Leader when PNCS members attended for months of January and February 2014;
    - Revised SLP assessment template with revisions highlighted; and
    - Revised OT/PT Peer Review Tool.
- **Interviews with**:
    - Terri Lykins, PNCS Director, RD, LMNT;
    - Marcie Regier, PNCS Nurse Coordinator, RN;
    - Debi Rinne, PNCS Discharge Nurse, RN;
    - Yvonne Parde, PNCS member, MS, OTR/L;
    - Tammy Weichel, Administrator for Solar Cottages;
    - Loree Crouse, Training Manager;

- Dr. Stull, Medical Director;
- Stacy Schlichtman, PNCS Member, MPT;
- Rudy Vasquez, PT;
- Rhiannon Svitak, MS, CCC/SLP/L; and
- Amy Vrbas, MS, CCC/SLP/L.

- **Observations of**:
  - Individuals in multiple residences and day programs.

Nutritional and Physical Supports/Therapeutic Interventions		
D120	The State shall provide each resident with effective, appropriate, and timely nutritional and physical supports to meet the individualized health care needs of each resident.	*As the principal requirement, adequate implementation of this subsection is dependent upon the State addressing Sections D121 through 140.* The Facility continued to update the physical and nutritional support system to provide supports to individuals at risk. As discussed in the Independent Expert's last report, this sustainable system was memorialized through the Physical and Nutritional Support Procedures, dated May 2013. There were four sections that included a total of 34 procedures: ▪ Section 1.0 Physical and Nutritional Consultative Services (PNCS); ▪ Section 2.0 Physical and Nutritional Supports (PNS); ▪ Section 3.0 Points of Service; ▪ Section 4.0 Urgent and Non-Urgent Triggers. Since the last review, Enhancing the Mealtime Experience, 8.5, effective 2/25/14, had been developed and implemented. These guidelines were incorporated in the Guidelines for the Home. The purpose of these general guidelines was to "ensure proper supports are available during meals and snacks." These guidelines addressed mealtime positioning, preparation before the meal, directions to follow during and after the meal, and additional "other" instructions. In addition, PNCS Scope, Risk Level and Entrance, PNS Procedure 1.0, revision dates of 2/5/14 and 3/13/14, had been renewed. These updates included adding the diagnoses of pneumonia and pneumonitis to the general criteria for individuals that qualified for PNCS assessment and/or re-assessment. These policy/procedure additions and revisions continued to further define and enhance the Facility's sustainable system for the provision of physical and nutritional supports.
Interdisciplinary Nutritional and Physical Support Team		
D121	The State shall ensure that an interdisciplinary team qualified to address nutritional and physical support issues addresses	*Under this subsection, the Monitoring Team has addressed the composition of the Physical Nutritional Consultation Services (PNCS) Team, the qualifications of team members, and the operation of the team. The assessment and planning processes in which the team is required to engage are discussed below in the sections that address Sections D122 through D140 of the Settlement Agreement.*

	residents' global nutritional and physical support needs. The State shall ensure that the team meets on a regular basis, and includes representation from various disciplines as required to meet the individualized needs of the residents including, nursing, a physician, nutrition, psychology, occupational therapy, speech therapy including a specialist in dysphagia, respiratory therapy, and physical therapy, as well as certain direct care workers from the particular resident's unit, and any other necessary specialists.	*Areas in which Less Oversight is Necessary* ▪ *Generally, the composition of the PNCS Team appeared appropriate. On a regular basis, participants in the meetings included a nurse, medical advisor, nutritionist, Occupational Therapist (OT), Speech Language Pathologist, and Physical Therapist (PT). At meetings at which plans for individuals were specifically discussed, members of the individuals' teams also participated. Note: At the time of the January 2012 review, more than one policy included information regarding the PNCS Team, and inconsistencies were noted. To avoid confusion, it is important that this be rectified. Based on the State's response, Facility staff were working on a revised policy.* ▪ *In addition to ongoing continuing education, PNSC Team members participated in training consultants the State hired provided, including clinical instruction in seating and alternate positioning.* *Areas Requiring Focused Effort* ▪ *At the time of the January 2012 review, the PNCS Team had not yet held meetings for all of the individuals on the Active PNCS Roster. Meetings needed to be held for approximately 20 individuals on the roster (30%). State states that this information was provided. The State will provide minutes from various meetings.* ▪ *In its response the Monitoring Team's report, the State indicated that a PNCS Team meeting was being held to review individuals on their roster who were hospitalized for a related condition. During upcoming reviews, the Monitoring Team will confirm this through review of related documentation. The process/guidelines for this needed to be reviewed and revised, as appropriate, to ensure that all related conditions are covered. For example, aspiration pneumonia or other respiratory issues, and skin breakdown (e.g., significant decubiti) were not included in the current policy.* ▪ *The PNCS Team's role in developing and implementing a transition plan for individuals hospitalized for a related condition also should be defined and procedures implemented. To address the State's concern about therapists not having privileges at hospitals, the policy should define how therapists assist in ensuring that while the person is hospitalized, that the POS plan(s) are implemented to ensure the individual's safety. The State is adding a discharge nurse who would call the hospital and check in with the primary nurse to make sure they understand the plans that have been sent. A staff person accompanies the person. Some of this depends on what the hospitalization involves.* As stated in the last report, the Independent Expert Team recommended that the areas previously identified as requiring focused effort for this provision be moved to the category of areas in which less oversight is necessary. On a very positive note, four members of the PNCS Team (i.e., PNCS Director, PNCS OT, and two PNCS RNs) presented *OT Expertise in Interdisciplinary Physical and Nutritional Support for Developmental Disabilities* at the National Occupational Therapy Association Conference in Baltimore, Maryland. Based

		on a review of the PowerPoint presentation presented during the conference, dated 4/7/14, the BSDC presenters introduced the purpose of the PNCS Team and described the PNCS process. The objectives of the presentation were: ▪ Identify OT discipline-based contributions to Physical Nutritional Support; ▪ Give examples of positioning, seating techniques and compensatory strategies that reduce the risk of choking or aspirating; and ▪ Analyze effectiveness of implemented interventions to mitigate the risk of aspiration in clinical and community settings. The members of the PNCS Team presented an individual's success story and how the provision of physical and nutritional supports had impacted the quality of his life in a variety of positive ways. This individual had experienced issues with maintaining his weight stability, complained of abdominal discomfort, had a diagnosis of gastroesophageal reflux disease (GERD), had a diagnosis of dysphagia, and had been diagnosed with pneumonia in 2010 and 2013. This individual had been assessed by the PNCS and a PNS plan had been developed and implemented to address his PNS concerns. After receiving these services and supports, this individual continued to maintain his independence at mealtimes, was working toward being more independent by learning to use a power wheelchair, was able to assist with activities of daily living, and had not had any illnesses in over 12 months. This presentation provided the opportunity for the PNCS Team members to share their experiences on a national level with other clinicians, but most importantly provided specific examples of how one individual's life had been significantly impacted in a positive way by receiving comprehensive physical and nutritional supports.
D122	The team shall identify each resident who has a nutritional and physical support need, or nutritional support problem, including all residents who are at risk of choking and/or aspirating, have dysphagia, difficulty swallowing, chewing, or retaining, food or liquids, have had aspiration pneumonia or other recurrent pneumonias, all residents who cannot feed themselves, any resident who currently receives or is a candidate to receive a feeding tube, and any resident with other medical or health care problems related to nutritional and physical support.	*Areas in which Less Oversight is Necessary* ▪ *BSDC had developed and appeared to be implementing reasonable methodologies for identifying individuals with needs for physical and nutritional support supports. The PNCS Operational Guidelines defined multiple pathways through which an individual could be identified with PNM concerns and referred to the PNCS Team. One pathway was through the identification of individuals at high risk in a number of related areas through the implementation of screening tools. Individuals receiving a high score on the 40Q Physical Nutritional Management (PNM) screening received a PNCS assessment. In addition, the PNCS Team assessed all individuals who did not eat orally and received enteral nutrition. Additional referrals to the PNCS Team included individuals who experienced a change in status. Individuals experiencing a change in status could be identified through multiple avenues.* *Areas Requiring Focused Effort* ▪ *Although it appeared that the PNCS Team's roster included individuals meeting the various criteria established, the reason for the referral was not adequately documented. The State indicated in its response that the form had been revised to address this issue. The Monitoring Team will confirm this during its upcoming visits.* As stated in the last report, the Independent Expert Team recommended that the areas previously

		identified as requiring focused effort for this provision be moved to the category of areas in which less oversight is necessary.
D123	After the team members contribute comprehensive assessment(s) of the resident's individualized needs to identify the causes for the nutritional and physical support problem(s), the team shall provide an analysis of the assessment(s) in a written comprehensive, coordinated nutritional and physical support action plan (hereinafter called "action plan") to meet the individualized needs of the residents and that adequately addresses the resident's positioning and nutritional support needs throughout the day. The analysis and action plan shall describe antecedents and interrelationships of the occurrence of physical and nutritional health risk indicators. The action plan shall be implemented for each resident and shall address proper mealtime/eating techniques and positioning of the residents during meals (including snacks), drinking, tooth brushing, dental exams, medication administration, bathing, nighttime/bedtime, and other routine activities that are likely to provoke nutritional and physical support problems. The plan shall include support strategies to anticipate, minimize, or remediate these concerns with written documentation of measurable, functional outcomes	*Areas in which Less Oversight is Necessary* • *Based on records reviewed for the January 2012 review, PNCS Enteral Nutrition Histories had been completed as part of the PNCS Team assessment process, as appropriate.* • *With regard to the Points of Service (POS) plans that BSDC used to address individuals' physical and nutritional support needs, record reviews showed the following plans/components of plans to be adequate:* ○ *Dining Cards for individuals who ate orally and/or received enteral nutrition;* ○ *POS plans for oral care and treatment in the dental clinic; and* ○ *Transfer instructions included in POS plans.* *Areas Requiring Focused Effort* ▪ *Policy: Although BSDC had made significant progress in defining the comprehensive assessment and plan development process, in order to ensure clear guidance was available and the changes made were sustainable, continued strengthening of the policy/operational guidelines was needed, including:* ○ *Description of the general responsibilities of core PNCS Team members;* ○ *Explanation of the discipline-specific responsibilities for the Coordinator (Nurse), Medical Advisor, OT, PT, SLP, RD, and RT;* ○ *Definition of the roles and responsibilities of the QDDP and IDT members in the PNCS process;* ○ *Definition of the role of the PNCS Oversight team member.* ○ *[In policy] The definition of the audit procedures for the multiple PNCS documents (i.e., PNCS assessment, health risk indicators, action plan tracking form, POS plans, competency performance check-offs, and monitoring forms). This section should also discuss the audit process for assessing the quality of PNCS documents, and determining whether or not the documents contain the components required in the guidelines. In its response, the State indicated the audit documentation processes were evolving. The Monitoring Team will review the changes the Facility has made. The State reported that it has covered these in the 34 procedures they have developed.* As stated in the last report, the Independent Expert Team recommended that the areas previously identified as requiring focused effort listed above be moved to the category of areas in which less oversight is necessary. ▪ *Policy: As BSDC staff indicated during the review, it will be important to ensure that incongruences between policies are corrected, and, if other policies provide relevant guidance (e.g., policies related to the provision of therapies), they are referenced. This is being finalized.* ▪ *Policy: The comprehensiveness of the policy should be addressed to include physical and*

	to be achieved.	*nutritional supports for all individuals who require them, not just those the PNCS Team supports. In the guidelines the State has created, the intent is not to replace the guidelines for the clinical/therapy departments. These guidelines will include pieces to address individuals' physical and nutritional supports. The Monitoring Team will review these documents.* As noted in a previous report, changes to policy had addressed these concerns, and the Independent Expert Team viewed this as an area requiring less oversight. ▪ *Practice: With regard to PNCS assessments, they should:* ○ *Identify the individual's current risk factors, including risks that might have changed due to a change in the individual status;* ○ *Include assessment of a full listing of PNM risk factors, such as respiratory compromise, skin integrity, infections, fluid imbalance, hypothermia, falls, fractures, osteoporosis, seizures, urinary tract infections, and/or polypharmacy and side effects. In its response, the State indicated that it had made changes to the assessment process to incorporate these risk factors. The Monitoring Team will confirm these changes. The State wants to make sure the PNCS Team is not prescriptive about the medical care, including the diagnostic piece. They want to focus on the immediate issues for the person. The Monitoring Team agrees this is a reasonable approach;* ○ *Indicate when and why an individual had been referred to the PNCS Team. The State indicated in its response that this had been added. The Monitoring Team will confirm these changes;* ○ *Provide an analysis of assessment data as the foundation for recommendations, interventions, and other strategies to minimize the identified PNM risk factors. The State has added a detailed summary of what happens at PNCS collectively as well as with individual therapists. They have added a number of other sections that should address this issue. A number of elements have been added, and the State will provide the Monitoring Team with more information during upcoming reviews. This additional documentation should help with the bridge the gap between what happens at the PNCS meeting and the documentation.* ○ *Identify individual-specific clinical baseline data to alert staff to an individual's change in health status. In its response, the State indicated the parameters for identifying PNCS at risk indicators were increasingly included in nursing care plans to enable the nurse who receives a report from a direct support professional to check the nursing care plan to see if a threshold has been met for referrals to PNCS or other disciplines. The Monitoring Team will confirm these changes. Individuals' triggers would be red flags that would go beyond the usual non-urgent triggers.* ▪ *Practice: With regard to PNCS action plans, they should:* ○ *Define clinical indicators to assist the team in determining when an individual is stable as well as unstable. In addition, the PNCS assessment and risk action plan should define the criteria for when nursing staff are to alert the PNCS to a health status change. The State indicated that these indicators are being included in the plans;*

		○ *Integrate individual-specific alert criteria into nursing care plans and define when nursing is to alert the PNCS Team. As discussed above, the State indicated in its response that work was being done on this. The Monitoring Team will confirm these changes;* As noted in the Independent Expert's previous reports, BSDC had made significant improvements in the areas listed above. During the current review, these areas received less oversight, and the Independent Expert Team recommends that this continue. ○ *Identify individual-specific triggers to be monitored and appropriate staff to monitor these triggers. In addition to defining nursing staff's role, action plans should incorporate individual-specific triggers that direct support professionals should monitor, document, and report, as appropriate;* Nursing care plans and POS plans were reviewed for five individuals (i.e., Individual #110, Individual #189, Individual #83, Individual #249, and Individual #61). Five of five individuals' (100%) nursing care plans integrated individual-specific triggers. The Independent Expert Team recommends that the requirement related to individual-specific triggers previously identified as requiring focused efforts be moved to the category of areas in which less oversight is necessary. ○ *Include goals on the tracking form that are functional and measurable. Most importantly, the goals should clearly identify how identified high-risk health indicators will be minimized. The State indicated in its response that this was being addressed on an ongoing basis. The Monitoring Team will confirm these changes.* ▪ *Practice: With regard to action plan implementation and follow-up, BSDC should:* ○ *Implement PNCS Tracking Form recommendations with a sense of urgency due to the high level of health risk identified with individuals that the PNCS Team supports. The concept is now understood that the PNCS acts like an emergency room to address highest risk issues;* ○ *Update PNCS Tracking Forms in a timely fashion to document closure on a recommendation. The State indicated in its response that additional action had been taken in this regard. The Monitoring Team will confirm these changes;* ○ *Based on the State's response, the PNCS Team members follow general guidelines for their professions for documentation in the Clinical Progress Notes. The Monitoring Team will use this as its standard in assessing progress notes;* The PNCS Team was tracking PNCS Action Plan assignments and status of completion in each of the ICFs/IDD. Spreadsheets were submitted for 2013 and 2014 for the following residences: 400 State, Sheridan, Solar, and Lake. The spreadsheet fields included the individual's name, home, PNCS action plan recommendations, discipline recommended, target date, status, and date achieved. The PNCS Team reported there were 111 Action Plan recommendations in 2013. Ten of the 111 recommendations were completed outside of the recommended time frame (i.e., 91% were timely completed). A review of the PNCS Action Plan Recommendation spreadsheets for 2014 indicated that

		all recommendations had a documented achievement date. As noted in the Independent Expert Team's previous report, BSDC had made significant improvements in the areas listed above. During the current review, these areas received less oversight, and the Independent Expert Team recommends that this continue. ○ *When the PNCS Team discharges an individual, they hold an IDT addendum meeting to present and discuss the PNCS Discharge Plan. This plan should continue to support the implementation of staff strategies (e.g., nursing, therapy and direct support professionals) to minimize identified health risk indicators. The State indicated in its response that this was an area requiring enhancement. The Monitoring Team will confirm that changes have occurred. BSDC has developed a procedure, and this procedure and the newly-hired nurse should play a major role in this process.* Based on previous positive changes as identified in the Independent Expert's previous report, the Independent Expert Team recommended that this area receive less oversight. ▪ *With regard to the Points of Service (POS) plans that BSDC used to address individuals' physical and nutritional support needs, record reviews showed the following plans/components of plans required improvement:* ○ *Identification of individual-specific triggers for individuals at highest risk to alert staff to a potential change in status. Although the State indicated these would be included in nursing care plans, they also should be on the POS plans because they are the documents to which direct support professionals have the most access. The POS should identify the practical signs that DSPs can pick up on, the nursing care plans would have the measurable outcomes based on these, and might have additional data they would collect that would be under nursing's purview;* As noted above, five of five nursing care plans identified individual-specific triggers to alert staff to a potential change in status. In addition, these individuals' POS plans included individual-specific triggers. The Independent Expert Team recommends that the preceding requirement related to individual-specific triggers be moved to the category of areas in which less oversight is necessary. ○ *Evidence is available that staff are trained on the description of the adaptive equipment's purpose, as well as adequate staff instructions on its use. Facility staff will identify where this is documented (e.g., in the IPP, daily care record, training records, etc.);* ○ *Inclusion in both the dining and medication plans of the time for an individual to remain upright after eating, receiving enteral nutrition, and/or medication administration;* ○ *Adequate POS plans for medication administration. The State indicated in its response that changes were being made as of July 1, 2012. The Monitoring Team will confirm these changes;*

		As noted in the Independent Expert's previous reports, BSDC had made significant improvements in the areas listed above. During the current review, these areas received less oversight, and the Independent Expert Team recommends that this continue. ○ *Adequate POS plans for wheelchair and alternate positioning instructions, including strategies for safe elevation ranges. In its response, the State indicated it was working on methods for providing safe elevation ranges. The Monitoring Team will confirm this during upcoming reviews;* ○ *Adequate POS plans for bathing, including strategies for safe elevation ranges; and* ○ *Adequate POS plans for personal care, including strategies for safe elevation ranges.* The Inclinometer Placement and Elevation Evaluation, PNS Procedure 2.0b, outlined the process for evaluating and/or marking the degree of elevation determined for each individual, as prioritized by risk level and/or medical referral. Individuals were to be prioritized for elevation evaluations based upon the presence of enteral feedings, medical referrals, or a high score on the PNM 40-Q Screen. BSDC continued to implement elevation assessments for individuals. A PNCS Elevation and Inclinometer Progress Tracking spreadsheet was maintained, including the following fields: first name, last name, home, date evaluation ordered by PCP, date evaluation completed, date PCP ordered evaluation, POS positioning plan revised to show degrees of elevation, bed marked with inclinometer, 30% or greater sampling shows inclinometer present on bed and HOB elevation accurate, and comments/follow-up. Based on interview with a PNCS Nurse, elevation assessments had been completed for all individuals with a PNS risk level of high. Individuals with a high PNS risk level were re-assessed on an annual basis prior to their IPP meeting or would be assessed sooner if they experienced a change in status. The next group of targeted individuals to receive elevation assessments had received a PNS risk level of moderate. After the completion of an elevation assessment, inclinometers had been placed on individuals' beds as required by assessment results. During the Independent Expert Monitoring Team's observations, inclinometers were present on individuals' beds. Point of Service plans were reviewed for the following five individuals: Individual #110, Individual #189, Individual #83, Individual #249, and Individual #61, and the following summarizes the findings: ▪ In three of three (100%) POS positioning plans for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair included instructions for staff to achieve safe elevation range(s). Individual #61 was ambulatory. Individual #83 used a wheelchair for off-home and long distance transportation. She did not use a wheelchair as primary mobility. ▪ In four of four (100%) POS positioning plans, for individuals with alternate positioning options (i.e., daytime and nighttime), staff instructions were included to achieve a safe elevation range. Individual #61 was ambulatory and independently repositioned himself. ▪ In four of four (100%) POS bathing plans, staff instructions were included to achieve a safe elevation range. Individual #61 was independent during bathing. ▪ Four of four (100%) POS personal care plans included staff instructions to achieve a safe elevation range. Individual #61 was independent with personal care.

- Four of four (100%) POS dressing plans included staff instructions to achieve a safe elevation range. Individual #61 was independent with dressing.
- Five of five (100%) POS instruction sheets for medication included staff instruction to achieve a safe elevation range.
- Five of five (100%) individuals' POS instruction sheets and/or nursing care plan for treatments included staff instruction to achieve a safe elevation range.
- In five of five (100%) individuals' dining plans, staff instructions were included to achieve a safe elevation range.
- Four of four (100%) individuals' POS oral care plans included staff instructions to achieve a safe elevation range. Individual #61 was independent with tooth brushing.

Beginning in October 2013, the consistency of language in individuals' POS plans was being reviewed on multiple levels. The Facility OTs and PTs were responsible for reviewing individuals' POS plans quarterly and prior to individuals' annual IPP meetings. The draft POS plans were reviewed by a POS review team, which included the QDDP Coordinator. Prior to the annual IPP meeting, the PNCS Team completed a final check.

The PNCS Team continued to conduct audits to assess their compliance with implementation of PNCS services and supports. PNM Auditing Categories and Indicators results continued to be completed and reported on a quarterly basis. For every exception to 100% compliance, the audit report noted the circumstances and reason why the criteria were not met. The documentation included a description of the resolution of the issue and the date resolved. These reports had the following sections:

- Assessment and Planning Process of PNCS;
- Components of Action Plans; and
- POS Development, Implementation, and Monitoring.

The PNM Auditing Categories and Indicators for Fourth Quarter 2013, identified one indicator that did not meet 100%:

- "Seven of 12 individualized triggers/thresholds are present on NCP [Nursing Care Plan] as worded on PNCS Action Plan." The action plan stated the PNCS Director and PNCS Nurse were meeting and talking with the Director of Nursing and nursing supervisors to offer clear directions to provide consistency between an individual's PNCS action plan, POS plans, and nursing care plans.

In summary, the Facility continued to develop, revise, and implement a sustainable system for the provision of physical and nutritional supports for individuals with identified needs. This system had been memorialized through the development and implementation of Physical and Nutritional Support Procedures. In addition, PNM audits were being conducted on a quarterly basis to assess the effectiveness of PNS-related services and supports. The audit results allowed the Facility to confirm whether or not established procedures were being followed. In addition, action plans identified what staff needed to do to fix indicators that fell below the agreed upon threshold. Individuals' POS and/or

		nursing care plans included elevation assessment information, which provided staff instructions to achieve a safe elevation range during multiple activities (i.e., wheelchair and alternate positioning, bathing, dressing, oral care, and personal care). In October 2013, a multi-level review system was initiated to review the consistency of language and content in POS plans. Nursing care plans included individual-specific triggers to alert staff to an individual's potential change of status. The remaining areas requiring focused effort within this section had shown improvement. The Independent Expert Team found sufficient evidence during this review to recommend that all provisions within this section be moved to the category of "Areas Requiring Less Oversight."
High Risk Criteria, Oversight		
D124	The State shall develop and implement criteria by which residents at the highest nutritional and physical risk are identified and assessed by the interdisciplinary nutritional and physical support team with regard to nutritional and physical support needs on an ongoing basis. The State shall prioritize these residents for the development and implementation of alternative and/or more tailored and intensive protections, supports, and services, where appropriate, that meet the residents' individualized needs.	*This has been addressed with regard to Sections D122 and D123 of the Settlement Agreement.*
D125	The State shall develop and implement a system to provide review and oversight of at-risk residents so that those identified as at highest risk may benefit promptly from comprehensive nutritional and physical supports. The system shall clearly define and document the oversight role with regard to ensuring the effectiveness of implementation strategies. The system shall develop and implement a methodology and clearly defined	*Due to the overlap in requirements related to oversight and monitoring, the requirements for this section are discussed in concert with the requirements for Section D127.* *<u>Areas in which Less Oversight is Necessary</u>* ▪ *Policy: The focus of POS monitoring was to: check staff compliance, redirect or re-educate staff through performance-based check offs in real time, reinforce need for POS plans and answer questions, assure changes in POS plans were understood and implemented quickly, review accuracy of POS and need for modification, and provide observational assurance that current POS measures were working. These multiple focuses of POS monitoring were appropriate.* *<u>Areas Requiring Focused Effort</u> – The State indicated in its response that changes had been made since the Monitoring Team's last review. The Monitoring Team will confirm these changes.* ▪ *In January 2012, implementation of the Dining/Meal Monitoring forms had just begun. Although this was positive, further evaluation of the Facility's implementation of this process is necessary.*

	policies and procedures related to follow-up and documentation to ensure that individualized outcomes are achieved.	▪ *The Facility also should monitor staff compliance with POS instructions for bathing/showering, tooth brushing, wheelchair and alternate positioning, personal care, and medication administration.* ▪ *The PNCS action plans should identify the need for individualized monitoring, including what will be monitored, who will monitor, when they will monitor, and how often they will monitor. Such individualized monitoring should be congruent with the individual's level of risk and current status.* ▪ *Staff responsible for conducting monitoring should successfully complete competency-based training, and inter-rater reliability should be established.* ▪ *On an individual basis, based on record review, even when issues were identified, documentation did not consistently show that appropriate follow-up occurred. The IDT, in conjunction with the PNCS Team, as appropriate, should analyze the monitoring results to determine if the recommended strategies are producing the desired outcome, and if not, make revisions to the plan, re-train staff, etc. Simple methods should be developed to document, monitor, and track clinical objective data to support the effective implementation of recommendations, as well as to document follow-up action taken and its effectiveness.* ▪ *On a systemic basis, although in conjunction with the QI Department work had been done to identify key indicators/outcome measures related to physical and nutritional supports, this system was not fully functional at the time of the January 2012 review.* ▪ *In addition, at the time of the January 2012 review, reports were not yet available that included analysis of data generated through either outcome measures or monitoring activities evaluating the effectiveness of physical and nutritional supports, and/or recommendations related to outcomes not being achieved. Limited information was beginning to be available through the ICF/ID quarterly reports in relation to mealtimes, etc.* The Facility continued to monitor PNS services and supports through the following: ▪ On 11/25/13, POS Monitoring Reports were initiated as a summary report, and distributed on a weekly basis to Area Administrators, Home Leaders, and Supervisors/Managers; ▪ PNCS Elevation and Inclinometer Progress Tracking; ▪ PNCS Action Plan assignments and status; ▪ Summary analysis of action plan assignment for 2013; ▪ Quarterly PNM Audits for Quarters 1 to 4, 2013; and ▪ Year-end QI Committee Reports for 2013. The Independent Expert Team found sufficient evidence during this review to recommend that all provisions within this section be moved to the category of "Areas Requiring Less Oversight."
Meals, Eating, Drinking, Plan Monitoring		
D126	The State shall develop and implement a system to ensure that staff do not engage residents in any mealtime/eating practice that	*Areas Requiring Focused Effort* ▪ *Although training was being provided in some key foundational areas, the competency-based check-offs were not adequate. The Clinical Services Department staff should review and update these performance check-offs by completing a task analysis of the steps required for each of the*

	poses an undue risk of harm to any resident, including assisting a resident to eat or drink who is improperly positioned or aligned, assisting a resident to eat or drink while the resident is coughing or exhibiting distress, assisting a resident to eat or drink with bites that are too large and/or faster than he or she can safely chew or swallow food and/or liquids. The State shall ensure that non-ambulatory residents shall be kept in proper alignment and shall not be laid flat on their backs during or after a meal until sufficient time has passed to allow digestion of food and/or liquids.	*skills learned in general PNM competency-based staff training.* ▪ *In addition, staff competencies in some foundational and/or individual-specific areas were not being tested (i.e., for skills on POS plans for bathing/showering, personal care, tooth brushing, and alternate positioning).* ▪ *Based on record reviews for a sample of individuals on the PNCS Team roster, limited staff competency performance check-offs with individuals' staff. Although BSDC presented a promising methodology for providing individual-specific training, at the time of the review, implementation had not begun.* ▪ *Although the Monitoring Team observed positive improvements during mealtimes, the Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems and/or regular dining chairs. Due to the risk in which this places individuals, this should be an area of focus.* As stated in the Independent Expert's last report, extensive support and PNS training had been provided to Health Care Coordinators (HCCs). In addition, the Basic Core Course for new employees provided an initial PNS presentation. Facility Dieticians also presented an advanced PNS session and included content for positioning and mealtimes. The Facility had developed and implemented 44 staff competency checklists. Each of these competency check-offs included multiple indicators that staff were responsible for demonstrating. Each indicator was scored as successful and/or unsuccessful. These checklists also included safety reminders. These competency checklists provided adequate, discrete steps for staff demonstration. The Facility's policies, procedures, and competency checklists provided a sustainable system to test staff competency in lifting, transfers, wheelchair positioning, alternate positioning, oral care, mealtimes, ambulation/mobility, and other therapy-related devices and/or techniques. The Monitoring Team observed multiple individuals during this review at mealtimes (i.e., Individual #48, Individual #107, Individual #363, Individual #140, Individual #163, Individual #23, and Individual #249) and in day programs (i.e., Individual #318, Individual #124, Individual #318, and Individual #186). These observations indicated that staff were following individuals' POS plans including dining plans. The Independent Expert Team recommends that all provisions within this section be moved to the category of "Areas Requiring Less Oversight."
D127	The State shall systematically and routinely monitor the implementation of the plans to ensure that the direct care staff safely and appropriately assist residents to eat and position the residents, especially for those residents who are at risk of	*Due to the overlap in requirements related to oversight and monitoring, the requirements for this section are discussed above with the requirements for Section D125.*

	aspirating, and to ensure that residents' nutritional and physical support plans are working effectively to meet the individualized needs of the residents to ameliorate the residents' physical and nutritional difficulties. The State shall ensure that all staff follow the instructions for each resident contained on the resident's nutritional and physical support plans.	
D128	The State shall develop and implement a system to ensure that staff assist residents with proper head alignment and other techniques during tooth-brushing, dental exams, and medication administration to minimize aspiration risk. The State shall ensure that there is proper coordination with dental and nursing personnel to accomplish this, and ensure that staff use proper infection control techniques during tooth-brushing to minimize risks of cross-contamination.	*The adequacy of POS plans for oral care and dental exams, and medication administration are addressed with regard to Section D123.* *Areas Requiring Focused Effort* ▪ *Based on records reviewed, POS plan formats did not provide direct support professionals and/or medication aides with infection control techniques to minimize cross-contamination. The State indicated in its response that enhancement of infection control practices was needed, and indicated that infection control practices were now included in the performance check-offs for oral care. The Monitoring Team will confirm these changes.* As indicated in the Independent Expert Team's last report, POS Process Guidelines for Oral Care and Medication Administration plan formats did provide direct support professionals and/or medication aides with infection control techniques to minimize cross-contamination. During this review, individual POS plans the Independent Expert Team reviewed confirmed the presence of infection control practices. This is an area in which the Independent Expert Team continues to recommend less oversight.
D129	The State shall ensure that residents who use a feeding tube are fed through the tube only when medically necessary. The State shall evaluate and document the continued appropriateness of the tubes on a regular basis, and, where appropriate, develop and implement plans to return residents to oral eating and drinking. The State shall ensure that residents who take nutrition	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January 2012 review, 14 of the 140 individuals at BSDC received enteral nutrition. Although no formal policy existed, as illustrated through record review and interview, the Facility's philosophy and actions supported the transition of individuals who were enterally nourished to a less restrictive approach, as appropriate. For example, for some individuals, enteral nutrition schedules were modified to promote times more typical of mealtimes, and a few individuals returned to oral intake. Other individuals avoided feeding tubes due to PNCS Team involvement.* *Areas Requiring Focused Effort* ▪ *To address the Settlement Agreement requirement that the "State shall evaluate and document the continued appropriateness of the tubes on a regular basis," clinicians and medical staff's*

	through a tube are provided with proper postural alignment and with adequate supervision to intervene whenever needed, especially if the resident is coughing during a tube feeding.	*assessments should be formally discussed and documented at least annually in the IPP.* ▪ *To ensure consistency over time, BSDC should memorialize in policy the expectations with regard to comprehensive assessment of individuals receiving enteral nutrition, and development and implementation of formal plans with measurable outcomes, as appropriate, to move individuals to less restrictive forms of nutrition.* The Facility continued to support transitioning individuals who received enteral nutrition to a less restrictive and more normative approach to receiving enteral nutrition. In addition, the staged progression for advancement for oral motor skills and goals continued to be expanded for individuals who IDTs had agreed to transition individuals to oral eating. The therapists were working to expand the provision of oral motor therapy from two times per week to three to four times per week, and in addition, to implement these programs during oral care. Based on the last review, the Independent Expert Team recommended that this subsection of the Settlement Agreement be an area requiring less oversight.
Therapy and Related Services		
D130	The State shall provide each resident with adequate, appropriate and timely occupational therapy, physical therapy, speech therapy, assistive technology support and physical assistance support services to meet the individualized needs of the residents, to enhance the capacity of the residents to function, and to help the residents live safely and as independently as possible.	*As the overarching requirement, adequate implementation of this subsection is dependent upon the State addressing Sections D131 through 140.*
Assessments		
D131	The State shall identify and provide a comprehensive assessment of all residents who are in need of occupational therapy, physical therapy, speech therapy, assistive technology and physical assistance supports. Such assessments shall address: diagnoses and/or description of significant health care issues; health risk indicators; orthopedic	*<u>Areas in which Less Oversight is Necessary</u>* ▪ *At the time of the January 2012 review, a revised OT/PT assessment format had been developed. It included all the requirements addressed in the Section D131 of the Settlement Agreement. Guiding Questions for the OT/PT Comprehensive Evaluation, undated, had been developed. Questions were presented under each section to guide the therapist through the assessment process.* *<u>Areas Requiring Focused Effort</u>* ▪ *Records reviewed did not include examples of the revised OT/PT assessment. The OT/PT assessments that were submitted using previous formats did not include the components this section of the Settlement Agreement requires. Further review is necessary to determine if the revised format results in adequate assessments, according to this provision.*

	concerns; musculoskeletal status, posture' functional mobility; functional performance of activities of daily living; communication; impact of health care issues on performance and therapeutic intervention; description of current therapeutic supports, which include mealtime, positioning and alignment, and assistive technology; and shall include baseline measurements where appropriate. Comprehensive assessments shall include analysis of findings to provide a rationale for recommendation and intervention strategies.	▪ *To ensure consistency over time, BSDC should memorialize in policy the expectations with regard to OT/PT assessments.* *Note: The status of SLP evaluations is discussed in further detail with regard to Section D140 of the Settlement Agreement.* Six individuals' OT/PT comprehensive assessments (i.e., Individual #186, Individual #162, Individual #191, Individual #156, Individual #153, and Individual #23) were reviewed for the presence of the necessary elements of an OT and PT assessment. This review found: ▪ Six of six individuals' OT/PT assessments (100%) included the components as required in the Settlement Agreement. Continued progress had been made in providing individuals with a more comprehensive OT/PT assessment. Since the last review, the OT/PT assessment template had been revised to include the impact of the individual's health care issues on performance and therapeutic intervention, PT and OT supports needed for successful community transition, and potential opportunities for skill acquisition programs. These were good changes. Since the last review, the three OT/PT audit tools (i.e., PT/OT Comprehensive Summary Chart Review, PT/OT Skilled Therapy Chart Review, and PT/OT Formal Habilitation Program Chart Review) had received another expansion. Additional comprehensive assessment areas to be audited included the impact of health care, recommendations for OT and/or PT needs, OT and PT supports for successful community transition, and potential opportunities for skills acquisition programs. The PT/OT Skilled Therapy Chart Review tool was expanded to include review of progress and discharge notes. The PT/OT Formal Habilitation Program Chart Review revision included a review of progress summaries. Guiding questions had been developed for the implementation of the PT/OT Comprehensive Summary Chart Review tool. The purpose of the guiding questions was to assist the clinician in completing a peer review of OT/PT documentation. Completed audits were to be reviewed and discussed on a quarterly basis for quality improvement purposes. The revision of the OT/PT Peer Review tool incorporated the components presented in OT/PT Therapy Department Procedures, including: Comprehensive Summary Evaluation Form Guiding Questions (3.0) Comprehensive Summary Evaluation (3.1), Comprehensive Worksheet Guiding Questions (4.0), and Comprehensive Worksheet (4.1). These were helpful changes. In summary, the Facility had adequate templates, including guiding questions, and policies related to the completion of OT/PT worksheets and comprehensive evaluations. Based on a review of the most recent OT/PT assessments, the individuals' OT/PT assessments were comprehensive and addressed the assessment components as outlined in Section D131. The Independent Expert Team recommends that this subsection of the Settlement Agreement be an area requiring less oversight.
D132	The State shall conduct a comprehensive assessment of all residents who use mobility, alternative/ therapeutic	*The requirements for this section are discussed above with the requirements for Section D131.*

	positioning, or other assistive technology supports (hereinafter, in this section, called "supports"). These assessments shall be completed in an interdisciplinary manner, including appropriate therapy staff and other appropriate staff, as well as direct care staff persons who know the resident well. Such assessments shall occur as frequently as needed to meet the individualized needs of the residents.	
Implementation		
D133	The State shall develop and implement occupational therapy, physical therapy, speech therapy, assistive technology and physical assistance supports for all residents in need of such services as an integral part of the residents' individualized service plans. These supports shall have functional outcome goals and expectations that are measurable and which shall be implemented so as to document observable changes in a resident's function as a result of therapy intervention. The State shall conduct a comprehensive review of any existing occupational therapy, physical therapy, speech therapy, assistive technology or physical assistance supports for residents and determine whether these supports adequately meet the needs of the residents and are working as intended. The State shall develop and implement new or modified individualized service	Since the last review, the following OT/PT procedures and guidelines had been revised, developed, and/or implemented: ▪ Mechanics, Gait and Ambulation Clinic (MGAC) Guidelines (1.1), effective date of 2/12/14, purpose was to "provide a professional, consultative review of body mechanics, gait and balance to individuals;" ▪ Wheelchair Clinic Guidance Procedure (2.0), effective date of 10/2013, purpose was to "provide professional consultative wheelchair services for routine equipment repairs, new equipment delivery, custom initial equipment fitting, evaluations for new equipment, posture/seating evaluations and vendor modifications for individuals;" ▪ Supportive Devices (2.13), effective date of 11/15/13, purpose was "to use supportive devices safely and effective in order to safeguard from injury and to protect people; ▪ Positioning Record Guidelines (3.1), effective date 4/2014, purpose was "based on clinician recommendation and utilization of the Braden Scale, individuals will be provided methods of data tracking to ensure proper positioning;" ▪ Adaptive Equipment Review Guidelines (4.0), effective date 4/2014, purpose was to "provide review to ensure the most updated equipment is in good working order, available and remains functional for the individual;" ▪ Comprehensive Summary Evaluation template and guiding questions (6.1), effective date 3/2014; ▪ Wheelchair Maintenance/Cleaning (6.3.34), effective date 2/2014, purpose was to "maintain cleanliness and prevent spread of disease and to ensure wheelchairs are in functional, safe working order;" ▪ Comprehensive Worksheet Guiding Questions (7.0), effective date 4/2014, purpose was "to define the combined comprehensive evaluation process for OTs and PTs;" ▪ Medical Orders (8.0), effective date 12/2013, purpose was to "ensure that therapy treatment is not initiated until a medical referral is received;" ▪ Occupational Therapy Skilled Treatment Evaluation and Plan of Care Guiding Questions (9.0),

	plans to meet the individualized needs of each resident identified in the assessments.	effective date 3/2014, purpose was to "define the treatment plan process for OTs;" ▪ Physical Therapy Skilled Treatment Evaluation and Plan of Care Guiding Questions (11.0), effective date 4/2014, purpose was to "define the treatment process for PTs;" ▪ PT/OT Formal Habilitation Plan Guiding Questions (13.0), effective date 4/2014, purpose was to "assist the therapist with thorough completion and documentation of a habilitation plan." ▪ Formal Habilitation Plan Program template (13.1a), effective date 3/2014; ▪ Formal Habilitation Plan Program Progress Summaries template (13.1b), effective date 3/2014; ▪ Guidelines for Initial, Weekly, Monthly, and Discharge Therapy Notes (14.0), effective date 10/2013, which defined the clinician's responsibilities in the provision of direct therapy; ▪ PT/OT Chart Review Guiding Questions (16.0), effective date 4/2014, purpose was to "to help the clinician thoroughly and accurately complete a chart review of documentation;" ▪ PT/OT Skilled Therapy Chart Review (16.1), effective date 3/2014; ▪ PT/OT Formal Habilitation Program Chart Review template (16.2), effective date 3/2014; ▪ PT/OT Comprehensive Summary Chart Review Form (16.3), effective date 3/2014, provided guiding questions to be completed during a chart review; and ▪ Monitoring of Lifts and Transfers (17.0), effective date 4/2014, purpose was to "provide a review to ensure proper implementation of transfers techniques and use of lifts." The implementation of these procedures continued to memorialize the process therapists were to follow in the provision of OT and PT services and supports. The development and implementation of such OT/PT procedures continued to be a positive development. *Areas Requiring Focused Effort* ▪ *Based on record reviews, areas that required improvement included:* ○ *For individuals for whom assessments identified therapy needs, plans needed to be developed consistently. Although in its response, the State provided some evidence of follow-up related to screening results and recommendations, complete documentation was not provided of either development of therapy plans or justification for not following through on recommendations;* ○ *Based on the Monitoring Team's review, therapy programs did not include functional, measureable outcome(s) as required by the Settlement Agreement. In its response the State provided documentation of some measurable and functional outcomes. However, they were located in various places in the record, including assessments as well as integrated progress notes. During upcoming reviews, in response to the Monitoring Team's requests for therapy plans, the Facility should identify in which specific document(s) it submits the therapy programs are embedded. Such plans would need to include methodology and schedules for implementation, as well as measurable outcomes. In the alternative, one format for an intervention plan could be developed, including all of the necessary components;* Nine individuals received direct OT and/or PT therapy interventions. Seven of these nine individuals' records (i.e., Individual #164, Individual #186, Individual #162, Individual #191, Individual #156,

		Individual #153, and Individual #23) were reviewed. Three of these seven individuals received direct PT interventions (i.e., Individual #164, Individual #186, and Individual #162) and the remaining four individuals (i.e., Individual #191, Individual #156, Individual #153, and Individual #23) received direct OT therapy intervention. Seven of seven individuals' direct therapy plans (100%) included functional, measureable outcomes. ○ *Therapy programs were not consistently integrated in the individual's IPP through habilitation goals, Positive Behavior Support Plans, nursing care plans, and informally through daily schedules. In its response, the State agreed that this was an area requiring improvement and indicated a commitment to work toward this goal;* Seven of seven individuals' IPPs (100%) discussed the individuals' direct OT/PT intervention programs. ○ *Skill acquisition programs, as appropriate, were not consistently developed and implemented to support direct therapy programs. In its response, the State indicated this was in place. The Monitoring Team will confirm this during upcoming reviews;* Seven of the seven individuals were in skilled therapy programs, and reinforcement of these skills had been transitioned to skill acquisition programs and/or daily activities for all of them (100%). ○ *OT and/or PT assessments for individuals receiving direct therapy did not include an analysis of assessment findings to justify the initiation and/or continuation of the direct therapy plans; and* Seven of the seven individuals' OT/PT assessments (100%) provided an analysis of assessment findings to justify the initiation of direct therapy intervention plans. ○ *Clinical data needed to be recorded and analyzed to validate the achievement of outcomes. It should be analyzed monthly to determine the efficacy of the interventions to support the continuation and/or discontinuation of programs. Indirect supports should be documented on at least a quarterly basis. In its response, the State indicated this was currently in paper format, but would be electronic soon. In response to requests for this information, electronic as well as paper documentation should be printed for the Monitoring Team.* Seven of seven individuals' receiving direct therapy (100%) had progress notes completed by the OT and/or PT after each intervention. These notes indicated if the individual was making progress and/or if there was a lack of progress with the stated objectives through the presentation of clinical data, identified the consistency of implementation, and, if appropriate, made recommendations for revisions in reference to the individual's progress and/or lack of progress. The clinical progress notes for this sample of individuals were adequate.

		Note: Individuals receiving speech therapy are discussed with regard to Section D140. In summary, with regard to the development and implementation of OT/PT direct intervention plans, the Facility continued to make progress. It had revised and/or developed new procedures and guidelines to memorialize the process therapists should follow as they developed and implemented direct therapy intervention plans. Based on a review of direct therapy plans, they included measurable objectives, therapy plans were discussed in the individuals' IPPs, therapists attended the IPP meetings, skill acquisition programs or other methods of generalizing the skills individuals were learning through direct therapy were included in individuals' IPPs, and therapists completed progress notes. The Independent Expert Team recommends that this subsection of the Settlement Agreement be an area requiring less oversight.
D134	The State shall develop and implement the supports based on the comprehensive assessments so as to ensure that the supports and positioning are promoting good body alignment and functional health status. The State shall ensure that for residents with physical and nutritional problems, the supports mitigate the occurrence of aspiration and support other therapy goals for each resident based on the individualized needs of each resident. Proper supports and positioning are to be integrated into the resident's activities throughout the day.	*Areas Requiring Focused Effort* ▪ *Concerns with regard to the quality of POS plans, which are addressed with regard to Section D123, also should be addressed in connection with this requirement.* ▪ *In order for POS plans "to be integrated into the resident's activities throughout the day," their integration into the IPP was an important step that, based on records reviewed, had not occurred.* ▪ *Given that IPP documentation showed varied attendance by therapists necessary to address the needs of individuals, this was an area also requiring attention. Their attendance at annual IPPs and special IPP meetings is important to discuss the rationale for an individual's POS plans, and be available to address any concerns IDT members might have with the POS plans.* As noted in the Independent Expert's last reports, BSDC had made improvements in the areas listed above. During the current review, these areas received less oversight, and the Independent Expert Team recommends that this continue.
Monitoring, Quality Assurance		
D135	The State shall systematically and routinely monitor the implementation of all of the aforementioned direct and indirect therapy supports to ensure that they are working effectively to achieve specific, measurable outcomes. The State shall develop and implement changes, whenever warranted, in	*Given that implementation of individual direct therapy and supports is tied closely to adequate monitoring and feedback "to ensure they are working effectively to achieve specific, measurable outcomes," the individual monitoring requirements have been incorporated above with regard to Section D133.* *With regard to systemic monitoring/quality assurance, at the time of the January review, the Facility presented a plan for finalizing its outcome measures/key indicators, including a time line. Efforts necessary to finalize and implement this process are discussed with regard to Section A14.* The Facility had developed multiple pathways for monitoring the implementation of individuals' direct and indirect therapy supports as well as tracking these results through quality assurance indicators.

	the residents' supports and interventions to meet the individualized needs of the residents. The State shall adequately document direct therapy supports and interventions to justify initiation, continuation or discontinuation of such services to determine a resident's progress and the efficacy of treatment interventions. Direct therapy supports and interventions shall be documented and a monthly summary should identify the resident's status, progress and a comparative analysis of progress over time. Implementation of indirect therapy supports shall be documented at least quarterly per the individualized service plan.	For example: ▪ The Facility continued to implement a monitoring system to assess staff implementation of individuals' POS plans. The POS monitoring system was designed to: evaluate the effectiveness of strategies, staff understanding and compliance, redirecting/reeducating staff through performance check-offs, reinforcement of the need for POS plans and answering staff questions, assuring changes in POS plans were understood and implemented quickly, and reviewing accuracy of POS plans and the need for modification, if necessary. As stated within this report, the Independent Expert Team's observations revealed staff compliance with individual's POS plans. ▪ An additional layer of oversight to assess the implementation of POS plans occurred through the PNM audit process. The PNCS Audits tracked concerns identified on POS monitoring forms and the status of documented follow-up to these identified concerns. For example, the PNM Auditing Categories and Indicators, Fourth Quarter 2013, reported that 60 of 283 POS monitors identified concerns. Sixty of 60 identified concerns on POS monitoring forms had documented follow-up to resolve these concerns. The Facility had established multiple pathways to assess the implementation of individual's POS plans. ▪ On 11/25/13, POS Monitoring Reports were initiated. These reports provided a summary of POS monitoring results for Home Leaders, Supervisors/Managers and Area Administrators. These summary reports identified the results of enhanced monitoring, including: individual's name, home, reason for monitoring, POS plan monitored (e.g., dining), frequency, findings, and follow-up. These monitoring reports were completed on a weekly basis and distributed to Home Leaders, Supervisors/Managers and Area Administrators. ▪ The PNCS Elevation and Inclinometer Progress Tracking system is discussed in further detail with regard to Section D123. ▪ The Facility's PNS Quality Improvement indicators included the following: o Fall incident review; o Rates of pneumonia; o Hospitalizations/ER transfers; o Pressure ulcer rates; o BMI less than 20; and o BMI equal to or greater than 30. These QI indicators/outcomes measures appeared to be adequate to track the Facility's success in working to minimize these PNS health risk factors and/or decrease hospitalization/ER transfers. The Year-end QI Committee report for 2013 reported on the status of these indicators. ▪ The PNCS Team continued to conduct Status Change meetings. This consisted of a review of several pieces of information, such as overnight nursing reports from the ICFs, medical consultation reports, and POS monitoring results, to name a few, that alerted the Team to individuals who might be in the early stages of experiencing a change in status. The PNCS Team had successfully transitioned to intervening more proactively with individuals and providing timely PNS services and supports. For example, the PNCS Team reported that the incidence of respiratory illnesses had significantly decreased from year to year. A PNCS Nurse tabulated the

		actual number of lower respiratory tract infections per year from 2010 to 2013, and found the following: ○ In 2010, there were 79 lower respiratory infections with the BSDC population that ranged from 162 to 172 individuals; ○ In 2011, there were 47 lower respiratory infections with a population range from 161 to 152 individuals; ○ In 2012, there were 24 lower respiratory tract infections, and the census ranged from 136 to 140 individuals; and ○ In 2013 there were 12 lower respiratory tract infections with a census of 126 individuals living on campus. The PNCS Team attributed the decrease in respiratory infections to the effectiveness of the implementation of combined PNS supports and staff implementation of these supports. ▪ The PNCS Team tracked timely implementation of action plan recommendations. A summary analysis of action plan completion for 2013 had been finalized. ▪ PNM Audits were completed quarterly and tracked compliance with established indicators. ▪ Furthermore, the Facility therapists completed a quarterly OT/PT and SLP peer review process to assess the adequacy of comprehensive assessments, skilled direct therapy, and formal habilitation programs. In summary, BSDC developed and implemented a number of processes aimed at improving outcomes for individuals, and was tracking some indicators that reflected outcomes for individuals. As discussed elsewhere in this report, efforts also had been undertaken to improve nursing care plans and IPPs to better define the individualized goals that should assist BSDC in measuring the efficacy of treatment on an ongoing and individual basis. Such data also could be used on to measure treatment effectiveness on a systemic level.
Assistive Technology and Supports		
D136	The State shall develop and implement a quality assurance system for speech, occupational and physical therapy supports and services to self-monitor for quality improvement so as to achieve functional outcomes for residents.	*Areas Requiring Focused Effort* ▪ *At the time of the January 2012 review, there was no formal quality assurance system defined in policy and/or procedure to self-audit the services and supports provided by the Clinical Services Department. The Clinical Services Director, in collaboration with Quality Assurance staff, should develop procedures to audit the quality of therapy assessments, direct and indirect therapy plans, and POS plans, as well as to assess the achievement of individuals' functional outcomes. In its response, the State indicated it was incorporating allied-health specific internal and external peer review processes. The Monitoring Team will review these activities.* This is discussed above with regard to Section 135.
D137	Residents shall be provided with necessary identified assistive technology supports such as: (a)	*Areas in which Less Oversight is Necessary* ▪ *At the time of the January 2012 review, the Facility had extended its contract with a PT consultant. The PT consultant was providing consultation to BSDC therapists, as well as*

	individualized, properly fitted seating systems that provide support and alignment for function that is optimal for that resident; (b) appropriate footwear while in such seating systems unless there is clear justification documented in the resident's record; and (c) seatbelts on wheelchairs and other mobility devices are appropriately positioned and adequately secured whenever appropriate to meet the needs of the residents. All supports shall be maintained in good working order and shall be repaired whenever necessary.	*completing individual screening(s) for wheelchair seating and alternate positioning needs. This had been a positive effort in ensuring individuals had properly fitted seating systems.* *Areas Requiring Focused Effort* ▪ *In order to ensure that individuals had been provided with the equipment identified in this subsection, and that the equipment properly fit them and met their needs, a system was needed to track and assess equipment on a regular basis. Although the Compliance Plan for Clinical/PNS indicated that the Wheelchair Clinic and Brace and Shoe Clinic routinely checked individuals for "fit, function, availability, condition and effectiveness of all adaptive equipment and assistive technology," the Facility did not provide documentation of individuals' attendance and/or the status of their prescribed equipment in the Wheelchair and/or Brace and Shoe clinics. In its response, the State acknowledged that improved documentation of procedures should be a goal and they would continue to work on optimizing these processes. The Monitoring Team will review the processes in its upcoming review.* ▪ *At the time of the January 2012 review, a new policy stated staff would complete a weekly wheelchair checklist. Staff was responsible for checking the wheelchair for cracks, loose components, missing parts, rough edges, worn or rusted parts, welds, and torn components. Urgent and non-urgent repairs were defined in the policy guidelines. The implementation of this policy requiring weekly wheelchair cleaning and checks was a positive move forward in ensuring individuals' wheelchairs were maintained in good working order. Implementation of the policy will require review during an upcoming visit to BSDC.* ▪ *With regard to the requirement that: "All supports shall be maintained in good working order and shall be repaired whenever necessary," work orders needed to be completed in a timely manner. However, at the time of the review, no formal procedures had been developed, such as defining the timelines for completion of work orders and/or prioritizing the completion of wheelchair orders. In its response, the State indicated that an OT was working on developing procedures for completion of work on wheelchairs and other adaptive equipment.* On a positive note, the Facility was supporting an OT to begin the process of completing the Assistive Technology Professional certification. The purpose of the Wheelchair Maintenance/Cleaning policy (6.3.34), effective date 2/2014, was to "maintain cleanliness and prevent spread of disease and to ensure wheelchair are in functional, safe working order." Staff were responsible for completing a weekly wheelchair checklist. Copies of the wheelchair checklist were faxed weekly to Developmental Therapy for review. If concerns were noted, this information was to be shared with the QDDP and Home Manager. If necessary, an action plan would be implemented. In addition, staff were to note if repairs were urgent and/or non-urgent. These repairs were defined in the procedure. This represented an appropriate system for ensuring wheelchairs were functional, safe, and in working order. Wheelchair Cleaning Review logs were submitted for five months (i.e., October, November, and December 2013, and January and February 2014). The following fields were tracked: name, home, wheelbase and date, seating system and date, no wheelchair, personal wheelchair, state-owned

		wheelchair, comments, and reviewed. However, the data from these monthly reviews were not trended and/or analyzed. The Independent Expert's Monitoring Team was not able to discern from these logs if individuals' wheelchairs had been cleaned on a weekly basis. As stated in previous reports, the OT/PT Department had developed policies and procedures to address the maintenance of individual's adaptive equipment.
Alternate Positioning, Lifts and Transfers		
D138	The State shall develop and implement effective alternative positioning options for residents.	*Areas in which Less Oversight is Necessary* ▪ *As stated above with regard to Section D123, the Facility had extended its contract with the PT consultant. The PT consultant was providing consultation to BSDC therapists, as well as completing individual screening(s) for wheelchair seating and alternate positioning needs. Based on interview, the implementation of therapeutic positioning had positive functional outcomes for individuals.* *Areas Requiring Focused Effort* ▪ *To ensure that individuals are receiving the alternative positioning recommended, the Clinical Services Department should develop a system to track the status of individual-specific recommendations made during these screenings. The State indicated they were developing a process to do this. The Monitoring Team will review the process.* Based on interview, the wheelchair and alternative positioning screenings were reviewed during the completion of the annual OT/PT assessment and integrated into assessment recommendations. These recommendations were discussed during the individual's annual IPP meeting. Five individuals' therapeutic positioning programs (i.e., Individual #162, Individual #362, Individual #154, Individual #47, and Individual #186) were reviewed. Five of five individuals' therapeutic positioning programs had functional and measurable goals (100%). The Facility reported as of 4/8/14, 46 individuals were provided therapeutic positioning in their residences and/or day programs. Sixteen of these individuals were positioned in more than one alternate therapeutic position. Equipment was present in homes such as EZ standers, sidelyers, walkers and reverse walkers. As stated in the last report, to provide more room for positioning, the site for day therapeutic positioning was moved to the OT/PT clinic. At the time of the review, a day program was being renovated and therapeutic positioning would resume in this day program when the renovations were completed. The Facility continued to be committed to expanding the number of individuals who received therapeutic positioning in multiple environments. These examples support the Facility's ongoing commitment to the provision and expansion of therapeutic positioning for individuals to minimize and/or reduce their risk factors. The Independent Expert Team recommends less oversight for this

		subsection and that this continue.
D139	The State shall develop and implement a system to ensure that staff utilize appropriate lifting and transfer techniques.	*This is addressed through Section D125 (re: monitoring) and Section D126 (re: competency-based training).*
Speech Therapy and Communication		
D140	With regard to speech therapy and communication, the State shall ensure that, on or before March 1, 2009, a qualified speech language pathologist with expertise in augmentative and alternative communication conducts comprehensive assessments of residents who need speech therapy and/or communication supports, develops and implements plans based on these assessments and monitors the implementation of the plans on an ongoing basis to ensure that they meet the individualized needs of the residents. The State shall ensure that such plans are reviewed and revised, as needed, but at least annually. The State shall develop and implement a screening and evaluation tool and process designed to identify residents who would benefit from the use of alternative and/or augmentative communication devices or systems.	Of note, the number of SLPs providing services and supports to individuals had expanded to four SLPs on campus. *Areas in which Less Oversight is Necessary* ▪ *SLPs were attending relevant continuing education, including training on augmentative and alternative communication.* ▪ *The SLP Communication Assessment format had been revised, and included a section "designed to identify residents who would benefit from the use of alternative and/or augmentative communication devices or systems." Draft Guiding Questions had been developed for the SLP Communication Assessment format.* ▪ *The Facility also had developed an Annual SLP Communication Screener. Guiding questions had been developed for the Annual SLP Communication Screener. It was positive that SLPs had developed a screening device with guiding questions.* ▪ *The Guiding Procedures for Communication Evaluation and Screenings had been developed. The procedures stated that an individual's communication skills would be screened annually by the SLP and the results would be presented to the IDT. Every three years an individual's communication skills would be evaluated. The evaluation would be scheduled near the time of the annual IPP to enable the SLP to report the results to the IDT members during the annual IPP.* ▪ *For individuals receiving direct speech therapy:* o *Direct speech therapy plans reflected recommendations from the SLP assessment;* o *Speech Therapy Program goals were functional and measurable; and* o *With some exceptions, Speech Therapy Program formats had been completed (i.e., goal, objectives, procedures, reinforcement, correction procedures, materials, special considerations, and data collection).* The Facility Quarterly QI Report for the Fourth Quarter of 2013 reported the following discussion and analysis for SLP Peer Reviews: ▪ Each SLP completed a quarterly peer review in four different areas (i.e., Standards of Practice, therapy, monthly/quarterly summaries, and annual assessment); ▪ Medical QI received 17 total reviews for 2013; ▪ All criteria carried the same weight in scoring; ▪ The target of 80% was met at 94% for 2013; and ▪ Chart reviews for the third and fourth quarters met all criteria at 100%, showing an improvement in documentation.

Areas Requiring Focused Effort

- *At the time of the review, the SLP Communication Assessment Format and Screening format had only begun the implementation phase. Further review will be necessary to determine if it generates assessments that meet the Settlement Agreement requirements.*

Twelve of 12 individuals' SLP communication assessments (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #166, Individual #177, Individual #180, Individual #117, Individual #235, Individual #372, and Individual #366) (100%) were adequate and contained the components required in the Settlement Agreement.

- *For individuals receiving direct speech therapy, efforts were needed to ensure:*
  - *Participation of the SLP in IPP planning meetings;*

The purpose of the Procedures for Speech Therapy Services (4.0), effective date 4/2014, was to "identify procedures for the provision of formal speech therapy." This procedure included the following sections: evaluation, IDT approval, therapy planning, scheduling, and dismissal. This procedure required the SLP to present SLP comprehensive evaluation findings and recommended goals and objectives to the IDT for approval. These recommendations would be presented during the next quarterly meeting or earlier, if clinically indicated. The IDT and SLP would determine if formal speech therapy was needed.

The IPPs and IPP addendums for nine individuals who received direct and/or consultative speech therapy programs were reviewed (i.e., Individual #163, Individual #55, Individual #167, Individual #186, Individual #166, Individual #177, Individual #180, Individual #117, and Individual #235). The annual IPP and/or IPP addendum signature sheet verified a SLP attended the annual IPP meeting for nine of nine individuals (100%).

  - *The skills learned in direct therapy are reinforced in IPP habilitation goals or informally in daily activities. In its response, the State acknowledged the need for improved integration between residential and therapeutic services. In addition, they submitted an email clarifying how direct speech therapy goals would be included in the IPPs. The Monitoring Team will review efforts in this regard; and*

Nine of the nine individuals in direct speech therapy (i.e., Individual #163, Individual #55, Individual #167, Individual #186, Individual #166, Individual #177, Individual #180, Individual #117, and Individual #235) had an IPP habilitation goal, as appropriate, to support skills learned in direct therapy (100%).

  - *Adequate monthly progress notes are available to the individual's team, including justification for initiation, continuation or discontinuation of direct therapy. In its*

response, the State indicated that documentation was available in e-record. The Facility should provide copies of these in response to the Monitoring Team's requests for monthly progress notes.

Nine of nine of the records of individuals (100%) (i.e., Individual #163, Individual #55, Individual #167, Individual #186, Individual #166, Individual #177, Individual #180, Individual #117, and Individual #235) that received direct speech interventions indicated SLPs completed adequate monthly and/or more frequent progress notes. The progress notes indicated if the individual made progress with the objective, reported on the consistency of implementation, and noted what would occur in the next therapy session.

- *For individuals with AAC systems, efforts were needed to ensure:*
  - *AAC systems are integrated, as appropriate, in multiple IPP habilitation programs;*

Nine of nine individuals' AAC systems (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366) were integrated, as appropriate, in IPP habilitation programs.

  - *IPPs support the use of AAC systems in activities throughout the 24-hour day;*

Nine of the nine individuals' IPPs and/or IPP addendums (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366) provided strategies for the use of individuals' systems throughout the 24-hour day.

  - *IPPs direct staff to ensure individuals' AAC systems travel with them throughout the day;*
  - *IPPs include staff instructions/support objectives to support the use of the individual's AAC systems in multiple natural environments;*

Nine of nine individuals with AAC systems had POS AAC plans developed (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366). These plans included a picture of the AAC system, defined when the individual should have access (e.g., during all waking hours), how the individual carried the system (e.g., pocket, purse, mount, etc.), habilitation plan goal, how to maintain the system, troubleshooting tips, and when to notify the SLP.

  - *Individual-specific communication strategies provide staff with an understanding of how to engage an individual with their AAC device;*

Nine of nine individuals' AAC POS plans (100%) had a section that provided staff strategies for engaging an individual with their AAC device. In addition, strategies also were included as part of their

habilitation plan. Staff referred to the habilitation plan as they were training the habilitation plan objective.

- *Staff instructions for AAC device(s) on how to operate (e.g., high tech devices) and maintain AAC devices are available; and*

Nine of nine individuals' POS AAC plans (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366) provided directions to staff for maintenance of the individuals' AAC systems.

- *Staff successfully complete competency-based training.*

Nine of nine individuals' staff (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366) completed competency-based training for and performance check-offs for the individuals' AAC devices.

Nine of nine individuals' AAC devices (100%) (i.e., Individual #163, Individual #412, Individual #55, Individual #167, Individual #186, Individual #177, Individual #117, Individual #372, and Individual #366) were monitored.

- *Although procedures for collaboration between the Behavior Support Team (formerly Psychology) and SLP, undated, had been developed, efforts were needed to ensure:*
  - *Adequate SLP assessments are conducted that include a comprehensive assessment of their potential for an AAC system;*
  - *The IPP and/or PBSP for individuals with PBSPs and an AAC device integrated the use of their prescribed AAC systems; and*
  - *Collaboration occurs between the speech language pathologist and psychologist in the development of the PBSP.*

  The State indicated in its response that SLPs and BCBAs were working with individuals to create alternative communication methods and environmental interactions. The Monitoring Team will review these efforts.

Based on interview, the SLPs viewed the collaboration between psychologists and SLPs as a significant improvement in the development of PBSPs for individuals with replacement behaviors related to communication. Seven individuals with PBSPs were reviewed, including their SLP assessments. This review revealed collaboration between the SLP and psychologist in the development of the PBSP in seven cases (100%) (i.e., Individual #412, Individual #166, Individual #180, Individual #117, Individual #235, Individual #372, and Individual #366).

- *With regard to monitoring, an AAC Maintenance Quarterly Summary Sheet, and the Socialization Habilitation Program Treatment Integrity policy were positive developments. However, at the*

time of the January 2012 review, data had not yet been analyzed. In addition to analyzing and using data to identify areas of success and areas needing improvement, additional information needed to be included in the policy, including:

- *Instructions for all monitoring forms for each monitoring indicator to support consistency in monitoring and inter-rater reliability;*
- *Identification, training, and validation process for Socialization Assistant monitors to achieve accurate scoring and a high level of inter-rater reliability;*
- *Feedback loop identified in which issues are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and*
- *Established thresholds for staff re-training.*

The purpose of the Procedures for AAC Point of Service and Maintenance (6.0), effective date of 4/2014, was to "implement and maintain functional AAC equipment." This procedure identified the following monitoring requirements:

- Human Services Treatment Specialists (HSTSs) will monitor all high tech electronic devices three times a week and low tech devices one time a week;
- HSTSs were responsible for reporting all malfunctioning equipment to the SLP immediately. The SLP was responsible for documenting the event in the AAC Maintenance log found in the speech drive;
- The AAC Maintenance Log documented the following: date reported, who reported, problem occurring, date repaired, and who completed the repair;
- The results of the weekly HSTS AAC monitoring were documented on the AAC Maintenance Monthly Summary Form. The completed form was forwarded to the SLP by the eighth of the month; and
- The SLP was responsible for completing a Monthly AAC Maintenance Summary in Avatar by the 15th of the month.

An AAC Maintenance Repair Log, from September 2013 to January 2014, identified 32 devices that were reported to the SLP with a problem. Twenty-four of the 32 devices were repaired on the same day the problem was reported. The remaining eight devices were repaired within a time frame of two days to sixteen days.

However, the procedure did include the components identified in the Areas Requiring Focused Effort.

In summary, as noted in the last report, the SLPs had made major positive revisions to the SLP assessment format, especially in the area of AAC assessment. Since the last review, the number of individuals provided direct therapy continued to increase. Based on a review of a sample of assessments, the quality of recent speech and communication assessments was consistently good. In addition, individuals' AAC systems were integrated into IPPs, and provided strategies for individuals' AAC systems to be available and utilized in multiple environments. As noted in the last report, POS plans for AAC devices had been developed, which was a positive addition. These plans included a

		picture of the AAC system, defined when the individual should have access (e.g., during all waking hours), how the individual carried the system (e.g., pocket, purse, mount, etc.), habilitation plan goal, how to maintain the system, troubleshooting tips, and when to notify the SLP. Competency-based training also had been provided to ensure staff knew how to use and assist individuals with the devices.

Recommendations: In previous reports, consistent with the definition of recommendations in the Settlement Agreement, the Independent Expert's recommendations to facilitate or sustain compliance were provided, and reports explicitly stated that the Settlement Agreement identifies the requirements for compliance, and the Independent Expert Team's recommendations were solely for the State's consideration. It was in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement. Over the course of the monitoring process, the Independent Expert Team offered many recommendations in the spirit of technical assistance. These recommendations were based on the Team's extensive experience with other large facilities and/or community systems and practices that had proven effective in addressing some of the issues the State faced. At this juncture, the Independent Expert has chosen not to include any recommendations in this report. The State has access to previous reports in which the Independent Expert Team's recommendations are documented should it choose to consider them.

Appendix A

U.S. v. Nebraska
Areas Requiring Focused Efforts and
State's Plans to Address the Remaining Issues

November 11, 2014

	Settlement Agreement Requirement	Status	State's Plan to Address Issue	Recommendation
B26	To foster each resident's self-determination and independence, the State shall use person-centered planning principles at every stage of the process. This shall facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs.	The Individual Personal Plans (IPPs) for individuals visited in the community during this review did not consistently document adequate structured habilitation commensurate with their needs and preferences, or the level of resources invested in their supports.	In 2013, the Qualified Developmental Disabilities Professional (QDDP) Support Services Team was created with a focus on community IPPs. Along with the DOJ Transition Manager, the QDDP Support Services Team staff were working on revising the IPP process for individuals in the community by means of adding prompts to the IPP Template, and developing and implementing a revised IPP Checklist, guidelines, and a process for the review of IPPs. Community Coordinator Specialists reportedly were using the IPP Checklist as a training and self-assessment tool for community ISPs. The State also was continuing its implementation of a pilot person-centered planning process. In its response to the draft report, the State indicated its intent to continue these efforts.	The State's efforts represented promising approaches to addressing the weaknesses in habilitation planning for individuals in the community, and should continue.
B43	The State shall take effective steps to support and expand service and provider capacity in the community so as to better serve residents placed and to be placed in the community. This shall include, but not be limited to, developing community capacity with regard to: housing and residential services; health care and other professional	<u>Behavior Supports</u> Based on the most recent review of a sample of Functional Behavior Assessments (FBAs) and Behavior Support Plans (BSPs), for some individuals, these supports were improved. These improvements often were a result of the contributions of the contracted personnel from outside the provider agency. However, some FBAs and BSPs continued to be substandard and	<u>Behavior Supports</u> The State has contracted with an agency to work with community providers to conduct 50 FBAs, and develop and train staff on BSPs for individuals served by a number of providers around the state. The goal of this initiative was that individuals would have improved behavioral assessment and intervention services, but also that provider capacity to conduct these services independently would be improved in that staff members would gain expertise through participation in the process. While the	<u>Behavior Supports</u> The State's current plan is a reasonable approach, and should continue. If not already incorporated in the States' plan, consideration also should be given to State Office providing: ▪ Leadership to produce a Therap template specifically designed for BSPs to assist providers in producing

	Settlement Agreement Requirement	Status	State's Plan to Address Issue	Recommendation
	services; specialty health care services; therapy services; communication and mobility supports; and psychological, behavioral, and psychiatric services.	this finding emphasizes the need for continued technical assistance to community providers and continued efforts to increase the capacity for adequate behavioral assessment and treatment in the community.	initiative initially was slowed due to staffing changes at the contracted agency, the initiative had been re-started and continued at the time of the most recent review. In addition, in the DDD Updates, the State recognized the need for ongoing training and technical assistance, and indicated: "the Division intends to offer monthly trainings through the end of 2014. The BSDC Team is developing an advanced level training for people who have background in FBA and BSP. The advanced level training will address requests from provider agencies for the opportunity to gain practical experience in applying the knowledge gained during the first training session addressing several case studies while benefitting from professional guidance by the BSDC trainers." In its response to the draft report, the State indicated that additional efforts included more training and technical assistance through the BSDC Behavioral Support Team and through collaboration with the State's contractor. The BSDC Behavioral Support Team also added more internship positions to continue to grow community capacity. The CMO also reportedly was working with the State Office Quality Improvement Committee to add QI indicators to assist the Division in proactively identifying situations that should trigger more detailed review by the DD Survey/Certification Team, who will have full access to the BSDC Behavioral Support Team.	understandable and technically adequate plans. ▪ Leadership to produce a more functional template for reporting progress that leads to providers conducting thoughtful analysis of the data and making programmatic decisions based on those analyses. ▪ Training on the use of the enhanced Therap system. ▪ Training and support to: a) bolster community providers' understanding of adequate monitoring of progress; b) improve the tools, methods and procedures for data collection to support improved monitoring of progress; c) ensure that CCSs have appropriate criteria by which to judge the adequacy of progress monitoring.
		<u>Physical and Nutritional Supports</u> A number of individuals that had transitioned from BSDC to the community had unaddressed needs that would benefit from	<u>Physical and Nutritional Supports</u> The State's contractor (i.e., OMNI) was coordinating the provision of statewide basic and advanced PNS courses. Beginning on May 2, 2014, the first of these courses, *Nutritional Assessment and Meal Planning for*	<u>Physical and Nutritional Supports</u> 1) The proposal for the provision of PNS training was a reasonable one that should assist in

	Settlement Agreement Requirement	Status	State's Plan to Address Issue	Recommendation
		coordinated therapeutic and medical/nursing supports (e.g., involvement of a PNCS Team).	*Individuals with Disabilities*, was scheduled for five different locations across Nebraska. The BSDC Director of Physical and Nutritional Supports and a BSDC Dietician were to present the training. This training was targeted for caregivers, provider staff, nurses, dieticians, dietary aids, quality assurance, and supervisory staff. Based on interviews with staff from the contracted agency, this was the first phase of PNS training to be provided in the community. A Community Services Education Proposal defined three basic and two advanced courses. The *It's My Life* Conference also was offering basic training on PNS topics. In its response to the draft report, the State indicated it intended: "to continue the current educational and collaborative efforts noted."	expanding basic capacity at the community provider level, as well as with therapists that attend the training. 2) The State, community providers, and other stakeholders should continue to collaborate in the development of a model and identification of a funding source(s) for a coordinated/ integrated sustainable system for providing physical and nutritional services and supports.
		<u>Speech and Communication</u> Speech therapy and communication assessments continued to be often inadequate and/or were not present to meet individuals' individualized, functional communication needs. As a result, it was unclear whether or not individuals that would benefit from speech therapy and/or alternative and augmentative communication devices or systems were accessing them.	In its response to the draft report, the State indicated that CCSs were trained on the content expectations for communication assessments. In addition, monitoring tools would continue to be evaluated for inclusion of new items to improve the quality of services provided to individuals. Also, the Division of Public Health's Health Licensure and Investigations Section had a new leader, and the DDD CMO was reaching out to share the concerns regarding quality of clinical care that have persisted over the past few years. The State indicated its intent to share these concerns through direct outreach to clinicians, potential outreach to the various licensing boards, outreach to the State's managed care entity, and continued community training on these topics, including sharing the BSDC Medical/Clinical Team's content guidelines and tools.	In addition to efforts to build capacity through training and collaboration, the State should consider developing therapy assessment content guidelines (i.e., OT, PT, and SLP) that would assist Community Coordination Specialists and community providers in requesting specific assessment content from a therapist when a referral is made for therapy assessments.

	Settlement Agreement Requirement	Status	State's Plan to Address Issue	Recommendation
B48 and B53	<u>B48</u> The State shall develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms shall serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight shall include regular inspections of community residential and program sites; regular face-to-face meetings with residents and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records. <u>B53</u> The State shall regularly review various community providers and programs to	The State had in place some components of a quality assurance/improvement system, including service coordination, to effectively monitor community protections, services and supports, but various components of this system remained works in progress. For example, some monitoring and data collection was occurring, and the Quality Improvement (QI) Committee and others were conducting some analysis of the data. However, efforts were still underway to ensure valid and reliable data were collected, and to fully analyze the data available, and take necessary action based on the findings. Improvements were seen with regard to the quality of Adult Protective Services (APS) investigations, but this was an area that continued to require focused efforts, particularly with regard to the need for the use of sufficient methodologies and reconciliation of evidence to support the findings.	The State recognized the need to continue building a strong quality improvement system. Some of the steps the State was taking included: ▪ A QI Subcommittee had begun to review and revise Service Coordination monitoring/audit tools; ▪ Once tools were finalized, the standardized data collected would be analyzed and used to identify areas requiring further follow-up; ▪ Definitions for reportable incidents were issued to providers, which should assist in collection of more complete and reliable incident data; ▪ The QI Committee had begun to review charts and statistics of incident data. Next steps included in-depth analysis and follow-up to trends identified; ▪ The QI Committee had begun to review data related to citations from certification/compliance reviews. Next steps included in-depth analysis and follow-up to trends identified; ▪ The State developed a report entitled "2013 Summary Information pertaining to Death of Individuals receiving Developmental Disabilities Community-Based Services," which included a number of charts and graphs, as well as narrative breakdowns of some important data. This was a helpful first step in the analysis of data related to deaths; ▪ A State Office Data Analyst had begun development of indicators, similar to those BSDC used, for use in the community, which once developed and implemented should address the need for review of "key-indicator	<u>Mortality Reviews</u> With regard to mortality reviews, necessary next steps include more in-depth analysis of the data and information from mortality reviews. Such in-depth analysis is necessary to make the information meaningful and usable for providers, and so that as a system, the data can be used to identify areas in need of attention. Such analysis might lead to the development of action plans or policy changes. <u>Quality of APS Investigations</u> Focus of quality efforts should be on the use of sufficient methodologies and reconciliation of evidence to support the findings.

	Settlement Agreement Requirement	Status	State's Plan to Address Issue	Recommendation
	identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State shall develop and implement effective strategies to any gaps or weaknesses or issues identified.		performance data;" and ▪ Since the last review, DCFS had initiated QI Case Reviews of investigation reports, which should assist in identifying areas needing improvement. In its response to the draft report, the State indicated: "The efforts relating to Quality Improvement will continue, including enhanced analysis of the mortality review as recommended. [The CMO] and the Medical Review Team have already began [sic] work with the Quality Improvement Committee to review systems and preferred outcomes to better identify quality indicators for routine analysis (very similar to the quality improvement system at BSDC). The Quality Improvement managers from Community Based Services and BSDC have already begun to work together to develop more cross-system systematic process to build upon the knowledge and progress that has been obtained at BDSC and expand those concepts into Community Based Services. With regard to APS, APS has implemented quality efforts focused on investigations, and it is expected that they will routinely report this information to the Quality Improvement Committee. Additionally, APS investigators continue to participate in the training sponsored by the Division, and that has led to improved quality."	

Appendix B

List of Acronyms

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ACT	Assertive Community Treatment
ACTS	Aspen Complaints/Incidents Tracking System
ADA	Americans with Disabilities Act
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine transaminase
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
BAR	Behavior Assessment Reports
BCBA	Board Certified Behavior Analyst
BID	Two times a day
BM	Bowel Movement
BMI	Body Mass Index
BP	Blood Pressure
BPD	Borderline Personality Disorder
BSDC	Beatrice State Developmental Center
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
BST	Behavior Support Team
CCS	Community Coordinator Specialist
CDD	Center for (Persons with) Developmental Disabilities
CEO	Chief Executive Officer
CEU	Continuing Education Unit
CFR	Code of Federal Regulations
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CQL	Council on Quality and Leadership
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
DD	Developmental Disability
DDD	Division of Developmental Disabilities
DDSC	Developmental Disabilities Service Coordination
DHHS	Department of Health and Human Services
DHHS - DDD	Department of Health and Human Services – Division of Developmental Disabilities

DNR	Do Not Resuscitate
DOJ	Department of Justice
DON	Director of Nursing
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
EEG	Electroencephalogram
EFH	Extended Family Home
EKG	Electrocardiogram
EPS	Extra Pyramidal Symptoms
ER	Emergency Room
FA	Functional Assessment
FAE	Fetal Alcohol Effects
FAS	Functional Assessment Summary
FAST	Functional Analysis Screening Tool
FBA	Functional Behavior Assessment
FDA	Federal Drug Administration
GER	General Event Report
GERD	Gastroesophageal Reflux Disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
GYN	Gynecology
H	High
H and P	History and Physical
HCBS	Home and Community-Based Services
HCC	Health Care Coordinators
HHS	Health and Human Services
HLRC	Human and Legal Rights Committee
HR	Human Resources
HRS	Health Risk Screen
HSTS	Human Services Treatment Specialists
ICD	Impulse Control Disorder
ICF/DD	Intermediate Care Facility for Individuals with Developmental Disabilities
ICF/MR	Intermediate Care Facility for Individuals with Mental Retardation
ID	Intellectual Disability
ID/DD	Intellectual Disability/Developmental Disability
IDP	Interdisciplinary Progress
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IM	Intramuscular
IPP	Individual Personal Plan
ITMS	Intensive Treatment Mobility Services
ITS	Intensive Treatment Services

LRA	Labor Relations Alternatives
LPN	Licensed Practical Nurse
LRC	Lincoln Regional Center
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligrams
MRC	Mortality Review Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MRT	Medical Review Team
MSU	Medical Services Unit
NIH	National Institutes of Health
NOS	Not Otherwise Specified
NP	Nurse Practitioner
ODD	Oppositional Defiant Disorder
OT(R)	Occupational Therapy
OTS	Outreach Treatment Services
PASRR	Preadmission Screening and Resident Review
PCP	Primary Care Practitioner
PMMS	Psychotropic Medication Monitoring Scales
PNCS	Physical and Nutritional Consultation Services
PNM	Physical and Nutritional Management
PNMS	Physical and Nutritional Management Screen
PNS	Physical and Nutritional Supports
POS	Points of Service
PRN	Pro Re Nata (“As Needed”)
PT	Physical Therapy
QA	Quality Assurance
QDDP	Qualified Developmental Disability Professional
QI	Quality Improvement
RD	Registered Dietician
RN	Registered Nurse
ROM	Range of Motion
RT	Respiratory Therapist
SGS	Spine Gait Screen
SIB	Self-Injurious Behavior
SLP	Speech Language Pathology
TBC	Team Behavioral Consultation
TD	Tardive Dyskinesia
TID	Three times a day
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection